

Chubb Orthodontics

TMJ AND FACIAL PAIN QUESTIONNAIRE

Your response to these questions will greatly assist us to make the proper diagnosis.

1. Check all of the symptoms that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Eye Pain or Burn |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain in front of Ear | <input type="checkbox"/> Teeth Sore or Sensitive |

2. Approximately how long has this problem occurred?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> 1 Month | <input type="checkbox"/> Over 6 Months |
| <input type="checkbox"/> 3 Months | <input type="checkbox"/> Over 1 Year |
| <input type="checkbox"/> 6 Months | <input type="checkbox"/> Over 5 Years |

3. Is this pain: Constant Aching Burning Stabbing

Worse in the morning Worse in the afternoon

Occurring When Chewing Occurring upon opening wide

4. Does your jaw click or pop? Yes No **If yes, which side?** Right Left Both

Does your jaw “catch” or “hang up”? **If yes, which side?** Right Left Both

Does your jaw lock open? Yes No

Does your jaw lock closed? Yes No

Does your jaw make a grinding sound? Yes No

If yes, how often does this occur? _____

If not occurring now, have these things occurred in the past? Yes No

5. Is there a history of trauma to the jaw? Can you recall any accident or injury when you hit or injured your jaw? Yes No

Comment _____

6. On a scale of 1 to 10 (ten being the best your jaw could feel)

• How are you feeling today?

1 2 3 4 5 6 7 8 9 10

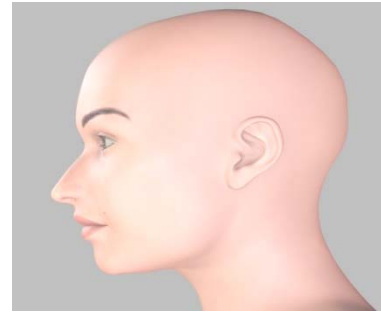
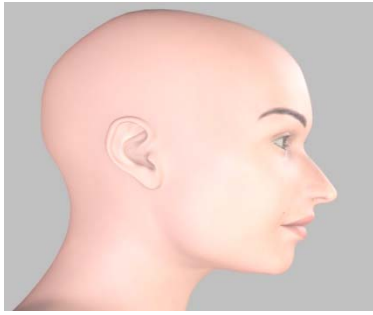
• When you are in discomfort due to your TMJ dysfunction, please rate yourself.

1 2 3 4 5 6 7 8 9 10

7. Draw an outline and shade the area(s) of your pain.

Right

Left



_____ DO NOT WRITE BELOW THIS LINE _____

TMJ EXAM

1. Muscle Palpation

2. Capsule Palpation

	Right	Left
Mass.	_____	_____
Temp.	_____	_____
Pteryg.	_____	_____
SCM	_____	_____
SML	_____	_____
Temporal Tendon	_____	_____

	Right	Left
Tenderness	_____	_____
Click	_____	_____
3. Joint Noise	_____	_____
Click	_____	_____
Reciprocal click	_____	_____
Crepitus	_____	_____

4. Range of Motion MO = _____ L = _____ R = _____ P = _____