Temporomandibular Jawbone disorder (TMD)
Temporomandibular Joint (TMJ) Evaluation Form (Completed by patient)

Evaluation Patient's Name: _____ _____
FIRST LAST

TODAYS DATE (MM/DD/YYYY): _____/_____/_____ AGE _____

In Your own words please explain your goals for coming here:

a) _____

b) _____

c) Date Problem Began___/____/_____ Age Problem Began: _____

d) Previous Facial Injury? YES NO If YES, When Was the Injury (MM/YY) ____/_____

e) If Yes, Please provide details of the Injury _____

f) _____

	Please Check If You Have Had Any Of The Following:		Good	Fair	Poor
	ORTHODONTICS	Date:			
	OCCLUSAL ADJUSTMENT	Date:			
	PHYSICAL THERAPY	Date:			
	TMJ SPLINT	Date:			
	TMJ ARTHROSCOPIC SURGERY	Date:			
	TMJ OPEN JOINT SURGERY	Date:			
	TMJ PROSTHETIC	Date:			

What doctors or other health care professionals have you seen regarding this Pain/Problem?

a) _____ (MM/YY) ____/_____

b) _____ (MM/YY) ____/_____

Past Medications Taken for TMJ: _____

_____

Current Medications Taken for TMJ: _____

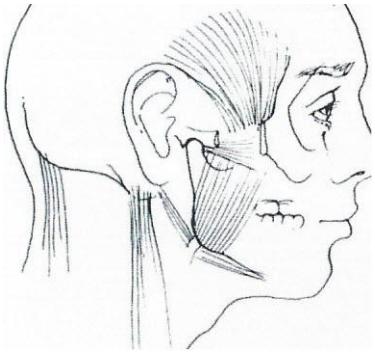
_____

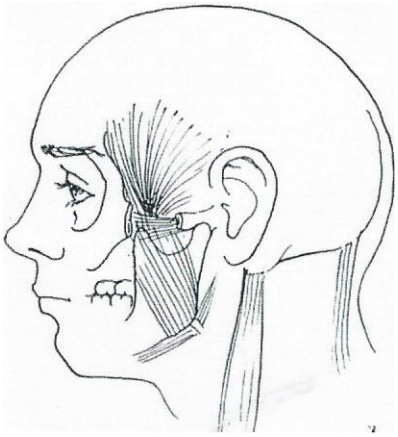
Indicate On The Following On The Following Scale How Severe Your Pain Is The Majority Of The Time.

+----------)

1 2 3 4 5 6 7 8 9 **10**

NO PAIN SEVERE PAIN





Indicate where on the diagrams you are having pain

Is the Pain? Constant Intermittent

Does It Hurt To Move Your Jaw? Yes No

Does It Hurt To Chew? Yes No

Does The Pain/Problem Limit Your Ability day to day? If So how? _____

_____

When is the pain worse? (Circle One) Morning Afternoon Evening

Other Time pain is noticeably worse? _____

Have you identified anything that makes the pain worse? _____

_____

Have you identified anything that reduces or mitigates the pain? _____

_____

Does Your Jaw Ever Lock Open? _____ Closed? _____

How Has This Been Treated? If yes, explain _____

_____ _____

Are you aware if there is a way to prevent, recover quickly or treat this? If yes, explain

_____ _____

_____

Do You Grind or Grit your Teeth? Yes No

Do You Have or Have Had Any of the Following?

Sinus Problems _____ Hearing Changes _____ Stressful Job _____

Sensitive Teeth _____ Ringing In Ears _____ Marital Problems _____

Periodontal Disease _____ Dizziness _____ Trouble Sleeping _____

Headaches _____ Shoulder Pain _____ Ulcers _____

Migraines _____	Arthritis _____	Nervous Stomach _____
Neck Ache _____	Skin Diseases _____	Allergies _____
Ear Ache _____	Depression _____	To What? _____

List Other Medical Problems**:** ___**_____**

_____

Using the scale below please mark how much the pain Is having an effect on my life.

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

No Effect	Slight Effect - I can function and am aware of pain	Moderate Effect Most days I can function	Severe Effect Most days I cannot function	Debilitating Rarely Can Function