TMJ EVALUATION

Name: _____ Date:_____

History & Symptoms

History of blow to head or face: No /Yes (If yes, please explain) _____
Jaw Pain (0-10) _____ Right/Left/Both Frequency _____

TMJ Noise: None/ Clicking/ Popping/ Grinding/ Cracking/ Other _____

Headaches: Yes _____ No _____ Frequency: _____

Ear Pain / Stuffiness _____ Right / Left Dizziness: Yes / No Tooth Pain: Yes / No

Symptoms relieved with: Heat / Ice / Rest / Soft Diet / Massage / Relaxation / Exercise / Medication / Other _____

Previous Treatment:_____

Current Medication/Oral Application:_____

Pertinent Medical History / Surgeries / Contraindications:_____

_____

Contributing Factors: Clenching / Grinding / Gum / Sleep Position / Chewing Habit/Phone / Computer Use

Functional Limitation:

Is your sleep interrupted: No / Yes (If yes, please explain) _____

Sleep Position: Stomach / Back / Side-R/L

Symptoms worse in AM: No / Yes

Jaw Activities: Pain Level (1-10) for each:

Talking _____ Dentistry _____ Yawning _____

Oral Hygiene _____ Laughing _____ Chewing _____

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Work or other Limitation: _____

Medical History:

FAMILY History: (Please check all that apply)

☐ Heart Disease	☐ Arthritis	☐ Osteoporosis	☐ Stroke
☐ Diabetes	☐ Hypertension	☐ Psychological	☐ Cancer

PERSONAL Medical History (Please check all that apply)

☐ Arthritis	☐ Broken bones/fractures	☐ Osteoporosis	☐ Blood disorder
☐ Heart Problems	☐ High blood pressure	☐ Stroke	☐ Depression
☐ Lung Problems	☐ Diabetes	☐ Cancer	☐ Skin Disease
☐ Seizures/Epilepsy	☐ Thyroid problem	☐ Low Blood Sugar	☐ Kidney Problems
☐ Allergies	☐ Multiple Sclerosis	☐ Infectious Disease	
☐ Ulcers/stomach problems		☐ Circulation/vascular problems	
☐ Other_____			

Symptoms YOU have experienced in the past year (Please check all that apply)

☐ Chest pain	☐ Loss of balance	☐ Weight loss/gain	☐ Heart palpitations
☐ Cough	☐ Joint pain/swelling	☐ Fever/ chills/ sweat	☐ Hoarseness
☐ Pain at night	☐ Headaches	☐ Shortness of breath	☐ Difficulty Sleeping
☐ Hearing problems	☐ Dizziness/blackout	☐ Vision problems	☐ Loss of appetite
☐ Coordination problems	☐ Nausea/vomiting	☐ Difficulty swallowing	☐ Weakness

Do you smoke? Yes / No Packs per day _____ Cigars / pipes per day _____

How many days per week do you consume alcoholic beverages _____ How many drinks per day? _____

Athletic / recreational activities? _____

Other Providers you have seen for this problem?

Dentist _____ Orthodontist _____ Massage Therapist _____ ENT _____ Chiropractor _____

Orthopedist _____ PCP _____ Rheumatologist _____ Other _____

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Patient Signature: _____ **Date: _____**

Parent / Guardian Signature _____ **Date: _____**