# TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

I. Name _____ Date _____

Age _____ Referred by _____

II. Which of the following do you have?

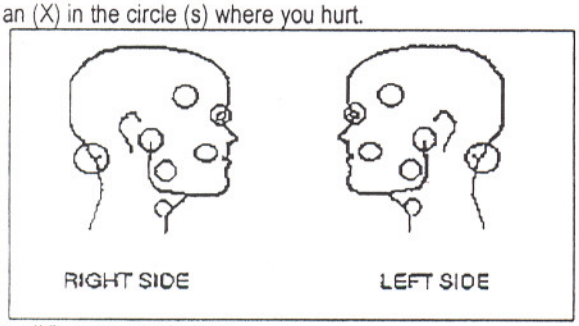
Headaches Neck pain Jaw pain Ear pain

Facial pain Other _____

Which side hurts (circle one) Right Left Both

Comments _____

III. Place an (X) in the circle (s) where you hurt.




Place an (X) on your pain level.

| RIGHT | | LEFT |
|---|---|---|
| 0 1 2 3 4 5 6 7 8 9 10 | BEST | 0 1 2 3 4 5 6 7 8 9 10 |
| 0 1 2 3 4 5 6 7 8 9 10 | AVG | 0 1 2 3 4 5 6 7 8 9 10 |
| 0 1 2 3 4 5 6 7 8 9 10 | WORST | 0 1 2 3 4 5 6 7 8 9 10 |

IV. How long have you had this pain? _____

Is this pain constant? Y N

Is the pain (circle all that apply) Aching Burning Stabbing

Other _____

V. Is the pain worst in the (circle all that apply)

Morning Afternoon Evening Night

VI. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply) Jaw Head Neck

(If so, please complete seperate Trauma Questionnaires for each trauma or whiplash)

VII. What makes the pain better? _____

What makes the pain worse? _____

What medication(s) do you take or have previously taken for your pain?

MEDICATION DOSE FREQUENCY

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General & Cosmetic Dentistry ■ Implants ■ TMJ ■ Headache & Myofacial Pain Management

# RANDOLPH DENTAL CARE

## TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

Name: _____ Date _____

VIII. Does it hurt to chew? Y N
Does it hurt to open wide? Y N
Which side of your jaw makes a popping noise? L R
Which side of your jaw makes a clicking noise? L R
Which side of your jaw makes other noises? L R
What noises? _____
When did you first notice joint noises? _____

IX. Has your jaw ever locked? Y N
Did it lock open or closed? Open Closed
When did this first happen? _____
When did this last happen? _____
Has your jaw ever slipped out of place? Y N
Which side? L R

X. Have you noticed a change in your bite? Y N
Did you notice a change at your front teeth? Y N
Did you notice a change at your back teeth? Y N
Has your profile changed? Y N
Have you noticed any crookedness or asymmetry in your jaw? Y N
When did you notice the asymmetry? _____

XI. Are your teeth sore or sensitive? Y N
Do you clench your teeth? Y N
Do you grind your teeth? Y N
Do you do this during the day or night? Day Night
When did you start clenching or grinding? _____

XII. Do you have problems with your ears? Y N _____
Dizziness? Y N Ringing? Y N
Hearing? Y N Other? _____

XIII. Is it difficult to swallow? Y N
Is it painful to swallow? Y N
Have you noticed lumps in your face? Y N
Throat? Y N Neck? Y N
Other _____

XIV. Have you had any prior treatment for TMJ? Y N
Splint? Y N When? _____
Nightguard? Y N When? _____
Did it help? Y N
Bite Adjustment? Y N When? _____
Orthodontics? Y N When? _____
Did it help? Y N
Surgery? Y N When? _____
What type and which side? _____
_____
Did it help? Y N
Explain _____
_____
_____

# RANDOLPH DENTAL CARE

## TMJ PROBLEM QUESTIONNAIRE

| PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE |
|---|---|

Name: _____ Date _____

XV. Describe your problems as you understand them: _____

_____

_____

_____

_____

_____

XVI. Reports may be sent to my:

Medical Doctor _____

Dentist _____

Other _____

XVII I have completed the above to the best of my knowledge and I consent to the use of my x-rays, records and photos for scientific publication or teaching providing my name remains anonymous.

_____

Signature

_____

Date

# TRAUMA QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

I. Name _____ Date _____

Date of Trauma _____

Was your trauma from (circle one)

Auto Accident Fight Fall Other _____

How did the trauma happen? _____

_____

_____

II Make of your car? _____ Your speed? _____

Make of other vehicle _____ Speed of other vehicle _____

Were you the (circle one) Driver Passenger front seat Passenger back seat

Other _____

Were you wearing a seat belt? Y N

Did you have a headrest? Y N

Shoulder strap? Y N Air bag? Y N

Did you strike the (circle all that apply)

Windshield Steering Wheel Dashboard

Other _____

III During the trauma, did you strike your (circle all that apply)

Skull Chest Lower jaw Neck Face around nose

Other _____

Did you have whiplash? Y N

Which of the following did you have as a result of the accident?

Cut Abrasions Bruises Bleeding from mouth

IV Were you knocked out? Y N How long? _____

What was your first memory after the trauma?

_____

_____

V Immediately post-trauma, were you treated (circle all that apply)

Emergency room Doctor's office Other

Name of facility _____

When were you first seen for evaluation after the trauma? _____

_____

VI Did you have x-rays of the (circle all that apply)

Face Neck Skull Other _____

Did you have a CT scan? Y N

Did you have an MRI scan? Y N

What other tests did you have? _____

_____

What did the emergency room doctor say was wrong and what treatment was prescribed? _____

_____

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## TRAUMA QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

Name _____ Date _____

VII. Where did you first hurt? _____

When did you first notice: Headache _____
Neck pain _____
Jaw pain _____
Ear pain _____
Jaw joint noises _____

Before the trauma, which of these symptoms did you have (circle all that apply)

Headache Neck pain Ear pain Jaw pain
Jaw joint noises Pain with chewing Jaw locking

VIII. Before this trauma, had you ever noticed any other injury to the (circle all that apply)

Face Head Neck Other _____
What type? _____
Have you had other accidents that may have injured your head or neck? Y N
What type? _____
When? _____

IX. List all doctors who have treated you for this trauma and explain what they have done

Emergency physician _____

Dentist _____

Oral surgeon _____

Orthopedic surgeon _____

Neurologist _____

Neurosurgeon _____

Chiropractor _____

Psychologist/Psychiatrist _____

Physical Therapist _____

Other _____

# TRAUMA QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

Name _____ Date _____

X Who do you feel is at fault for your trauma? _____

Explain _____

_____

XI Is your pain getting (circle one)

Worse ? Better? Unchanged?

Over what time period _____

Do you expect your pain will get (circle one)

Worse? Better? Unchanged?

XII Your attorney's name _____

Do you expect to file a lawsuit? Y N

When? _____

XIII Have you ever sued or threatened to sue (circle all that apply)

Physician? Dentist? Hospital? Emergency Room?

Explain _____

_____

XIV I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing.

_____ _____

Signature Date