

TMJ PATIENT INFORMATION

OFFICE USE ONLY	
Patient ID: _____	Date: ____/____/20____ <small>month day year</small>
Site: <input type="checkbox"/> UIHC <input type="checkbox"/> CC	Visit #: ____

1. Are you...
 Male Female?

2. Where do you live (city, state)? _____

3. What is your date of birth? ____/____/19____
month day year

4. What is your race?
 American Indian Black or African American Mixed Race
 Asian or Pacific Islander Hispanic White

5. Please check your highest educational level:
 Some High School Some College Post Graduate Degree
 High School Diploma College Degree Professional School

6. What is your occupation? _____

7. Please check the box that applies.
 Single Married/living with partner Divorced Widowed

8. How much do you weigh? ____ lbs

9. How tall are you? ____ ft ____ in

10. How long have you had your TMJ symptoms? ____ years, or ____ months, or ____ weeks

11. Have you ever received any type of health care for TMJ?
 No Yes

11a. If "Yes," please check which type of health care provider you last saw and give the approximate date of that visit.

DC (Chiropractor)Date last seen? ____/____/____
month year

DDS (Dentist).....Date last seen? ____/____/____
month year

Other (please specify)_____ Date last seen? ____/____/____
month year

12. Do you take any medications for your TMJ symptoms?
 No Yes

12a. If "Yes," Please list:

Prescription Medications

Non-Prescription Medications

**TMJ PATIENT
QUESTIONNAIRE**

OFFICE USE ONLY

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Date: ___/___/20___
month day year

Site: UIHC CC

Visit #: ___

Please check the box below which best describes the amount of improvement you experienced in your symptoms during this course of care.

Your symptoms:

- 1 Improved completely (they are now gone).
- 2 Got a lot better but are not gone.
- 3 Got a little better.
- 4 Stayed the same as before I started treatment here.
- 5 Got a little worse.
- 6 Got a lot worse.

Do you have any comments about the care you received that you would like to tell us? Please provide them below.

JAW SYMPTOM QUESTIONNAIRE

OFFICE USE ONLY				
Patient ID: _____	Date: ____/____/20____			
	month	day	year	
Site: <input type="checkbox"/> UIHC <input type="checkbox"/> CC _____	Visit #: _____			

Please check the appropriate answer to the following questions.

A. Jaw Pain Questions

	Doesn't hurt at all	Hurts a little	Hurts a lot	Almost unbearable	Unbearable pain without relief
1. Does it hurt when you open wide or yawn?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. Does it hurt when you chew, or use the jaws? .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. Does it hurt when you are not chewing or using the jaws?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. Is your pain worse on waking?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. Do you have pain in front of the ear or ear aches?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. Do you have jaw muscle (cheek) pain?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. Do you have pain in the temples?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8. Do you have pain or soreness in the teeth?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

B. Jaw Function Questions

	No	Maybe a little	Quite a lot	Almost all the time	All the time without stopping
1. Do your jaw joints make noise so that it bothers you or others?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. Do you find it difficult to open your mouth wide?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. Does your jaw ever get stuck (lock) as you open it?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. Does your jaw ever lock open so that you cannot close it?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. Is your bite uncomfortable?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. Do you ever bite the inside of your cheeks, lips, or tongue?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. Do you clench or grind your teeth while you are awake?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8. Do you clench or grind your teeth while you are asleep?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

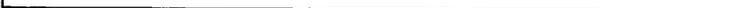
Reconstructed and enhanced from Diagnostic and Surgical Arthroscopy of the Temporomandibular Joint. Sanders, Murakami, & Clark (1989), p 124

**TMJ PAIN
VISUAL ANALOG
SCALE**

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Please think about how you are feeling right now - your sense of how much pain or discomfort you feel in your face or jaw. On the line below, make a straight vertical (up and down) mark on the line to show how you **feel right now**.

NO PAIN or
discomfort in
face or jaw



WORST PAIN you
could possibly feel in
face or jaw

Maximum active opening of the mouth without pain: ____ mm