**TMJ SYNDROME AND MYOFASCIAL PAIN HEALTH HISTORY QUESTIONNAIRE**

 Date of Birth/Age:

Sex: M or F (circle one) SSN or SIN:

Address: City:

State/Province: Zip/Postal Code:

**CHIEF COMPLAINT(S)**

1) Describe what you think the problem is:

2) What do you think caused this problem?



**MEDICAL AND DENTAL HISTORY**

1) Are you presently under the care of a physician or have you been in the past year? Yes No

Physician’s name: 

**TREATMENT**



2) How would you describe your overall physical health? (circle one) Poor Average Excellent

3) How would you describe your dental health? (circle one) Poor Average Excellent

 Date of last appointment:

4) Have you had any major dental treatment in the last two years? (circle one) Yes No

If yes, please mark procedure(s):   Oral Surgery 



**HISTORY OF INJURY AND TRAUMA**

1) Is there any childhood history of falls, acidents of injury to the face of head? Yes No

Describe:

2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)

Yes No Describe:



Yes No Describe:

**FACIAL PAIN PAST TREATMENT**

1) Have you ever been examined for a TMD problem before? Yes No

If yes, by whom? When?





Is this a new problem? Yes No



5) Have you ever had physical therapy for TMD? Yes No If yes, by whom? When?

6) Have you ever received treatment for jaw problems? Yes NO If yes, by whom? When? What was the treatment? (Please mark Below)

Bite Splint  Physical Therapy Occlusal Adjustment 

Counseling Surgery

Other (Please explain):

7) Have you ever had injections for your TMD with muscle relaxants (Botox, Flexeril) cortisone or anti-inflammatories?

Yes No  Yes No

How many dental appliances have you worn? 8) Were these appliances effective? Yes No



**CURRENT STRESS FACTORS (PLEASE MARK EACH FACTOR THAT APPLIES TO YOU)**

Death of a Spouse Major Illness or Injury Major Health Change in Family

Business Adjustment Divorce Pending Marriage Financial Problems Pregnancy Career Change Fired from Work  Debt

Death of a Family Member New Person Joins Family Marital Separation Other

**CURRENT AND PREVIOUS HABITS (PLEASE MARK YOUR ANSWER TO EACH QUESTION)**

1) Do you clench your teeth together under stress?..................................................Yes No Don’t Know

2) Do you grind/clench your teeth at night?...............................................................Yes No Don’t Know  No Don’t Know  No Don’t Know

Describe:

**CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES)**

**A. HEAD PAIN, HEADACHES, FACIAL PAIN**

Forehead L R Temples L R

Migraine Type Headaches

Cluster Headaches Maxillary Sinus

Headaches (under the eyes)

Occipital Headaches (back of the head



Hair and/or Scalp Painful to Touch

**B. EYE PAIN / EAR ORBITAL PROBLEMS** Eye Pain - Above, Below or Behind Bloodshot Eyes

Blurring of Vision

Bulging Appearance Pressure Behind the Eyes



Watering of the Eyes

Drooping of the Eyelids

**C. MOUTH, FACE, CHEEK**

**& CHIN PROBLEMS**

Discomfort

Limited Opening

Inability to Open Smoothly

**D . TEETH & GUM PROBLEMS E. JAW & JAW JOINT (TMD) PROBLEMS**

Clenching, Grinding at Night Looseness and/or Soreness of Back teeth

Clicking, Popping Jaw Joints



Jaw Locking Opened

or Closed

Pain in Cheek Muscles

Uncontrollable Jaw/

Tongue Movements

**F. PAIN, EAR PROBLEMS,**  **POSTURAL IMBALANCES**

Hissing, Buzzing, or Ringing Sounds

**G. NECK & SHOULDER PAIN**



Ear Pain without Infection Numbness, tingling or pain in arm

Clogged, Stuffy, Itchy Ears Neck Pain

Balance Problems – “Vertigo” Tired, Sore Neck Muscle

Diminished Hearing Back Pain, Upper and Lower Shoulder Aches

**H. THROAT PROBLEM**

Sore Throat

Tightness of Throat



**I. OTHER PAIN**

**CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED**

NO PAIN MODERATE PAIN SEVERE PAIN

1) Degree of current TMD pain: 0 1 2 3 4 5 6 7 8 9 10

2) Frequency of TMD pain: Daily Weekly Monthly Semi-Annually 

 How long does it last? What makes it worse?









Yes No If so, what type?

How long?



Conditional?

Yes No



5) Are you aware of anything that makes your pain worse? Yes No If yes, what?

6) Does your jaw make noise? Yes No If so, when and how? Right Clicking/Popping Grinding Other Clicking/Popping Grinding Other

7) Does your jaw lock open? Yes No 



8) Has your jaw ever locked closed or partly closed? Yes No 



9) Have any dental appliances been prescribed? Yes No

If yes, by whom?

When? Describe:

When do you wear your dental appliances?