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? Physician’s name:  | Yes | No |  |
| **TREATMENT** |  |  |  |
|  |  |  |  |
| 1. How would you describe your overall physical health? (circle one) Poor
2. How would you describe your dental health? (circle one) Poor
 |  | Average Average | Excellent Excellent |

 Date of last appointment:

1. 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, accidents of injury to the face of head? Yes No

Describe:

1. 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

4

1. Have you ever had physical therapy for TMD? Yes No If yes, by whom? When?
2. 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):

1. 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?

1. 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)**

## 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

## 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

## MOUTH, FACE, CHEEK & CHIN PROBLEMS

Discomfort Limited Opening

Inability to Open Smoothly

## TEETH & GUM PROBLEMS

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

Tooth Pain

## JAW & JAW JOINT (TMD) PROBLEMS

Clicking, Popping Jaw Joints



Jaw Locking Opened or Closed Pain in Cheek Muscles

Uncontrollable Jaw/ Tongue Movements

## PAIN, EAR PROBLEMS, POSTURAL IMBALANCES

Hissing, Buzzing, or Ringing Sounds

Ear Pain without Infection Clogged, Stuffy, Itchy Ears Balance Problems – “Vertigo” Diminished Hearing

## NECK & SHOULDER PAIN

Arm and Finger Tingling, Numbness, Pain



Neck Pain

Tired, Sore Neck Muscle Back Pain, Upper and Lower Shoulder Aches

## THROAT PROBLEMS



Tightness of Throat Sore Throat

 

* 1. **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?

Yes

No

Conditional?



1. Are you aware of anything that makes your pain worse? Yes No If yes, what?
2. Does your jaw make noise? Yes No If so, when and how?

Right



1. Does your jaw lock open? Yes

Clicking/Popping Clicking/Popping No

Grinding Grinding

Other

Other

1. Has your jaw ever locked closed or partly closed? Yes No

1. Have any dental appliances been prescribed? Yes No

If yes, by whom?

When? Describe:

When do you wear your dental appliances?