TMJ – Facial Pain

Name ______________________ Date __________
Date of Birth ______________________ Age __________
Address ______________________

City __________ State ______ Zip ______ Phone __________
Referred By ______________________

Major Reason for Current Evaluation

Describe what you think the problem is ______________________
____
What do you think caused this problem? ______________________
____
Describe, in order (first to last), what you expect from your treatment ______________________
____

General History

Are you presently under the care of a physician or have you been in the past year? ☐ Yes ☐ No
Physician's Name ______________ Condition Treated ______________
Treatment ______________________
Name of medications(s) you are currently taking ______________________
____

	Poor	Average	Excellent
How would you describe your overall health?	0 1 2 3	4 5 6 7	8 9 10
How would you describe your dental health?	0 1 2 3	4 5 6 7	8 9 10

Dentist's Name ______________ Date of last appointment ______________
Have you had any major dental treatment in the last two years? ☐ Yes ☐ No
If yes, choose all that apply: ☐ Orthodontics ☐ Periodontics ☐ Oral Surgery ☐ Restorative
Date(s) of third molar (wisdom teeth) extraction(s) ______________________

Facial Injury/ Trauma History

Is there any childhood history of falls, accidents or injury to the face or head?
Describe: ______________________
Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact, ect.)
Describe: ______________________
Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)
Describe: ______________________

TMD Treatment History

Have you ever been examined for a TMD problem before? ☐ Yes ☐ No
If yes, by whom? ______________ When? ______________
What was the nature of the problem? (Pain, noise, limitation of movement) ______________
____
What was the duration of the problem? [   ] Months [   ] Years
Is this a new problem? ☐ Yes ☐ No
Is the problem getting better, worse or staying the same? ______________
Have you ever had physical therapy for TMD? ☐ Yes ☐ No
If yes, by whom? ______________ When? ______________
Have you ever received treatment for jaw problems? Yes No
Is yes, by whom? ______________ When? ______________
What was the treatment? Choose all that apply: ☐ Bite Splint ☐ Medication ☐ Physical Therapy ☐ Occlusal Adjustment ☐ Orthodontics ☐ Counseling ☐ Surgery
Other: (Please explain) ______________________

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Current Medications/ Appliances

Pain scale: None Moderate Severe

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

Frequency of TMD pain: ☐ Daily ☐ Weekly ☐ Monthly ☐ Semi-Annually

Is there a pattern related to pain occurrence? ☐ Upon Wakening ☐ Morning ☐ Afternoon ☐ Evening ☐ After Eating

Are you taking medication for the TMD problem? If so, what type? ______

How long? ______ Who prescribed the medication? ______

Are the medications that you take effective? ☐ Yes ☐ No Conditional: ______

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

Does your jaw make noise? ☐ Yes ☐ No

Right ☐ Clicking ☐ Popping ☐ Grinding Other ______

Left ☐ Clicking ☐ Popping ☐ Grinding Other ______

Does your jaw lock open? ☐ ______

How often? ______

Have any dental appliances been prescribed? ☐ Yes ☐ No If yes, by whom? ______

When? ______ Describe ______

Are these appliances effective? ☐ Yes ☐ No

Is there any additional information that can help us in this area? ______

Current Stress Factors (Please check each factor that applies to you)

[☐] Death of Spouse
[☐] Business Adjustment
[☐] Financial Problems
[☐] Fired from Work
[☐] Death of a Family Member
[☐] Major Illness or Injury
[☐] Divorce
[☐] Pregnancy
[☐] Marital Reconciliation
[☐] New Person Joins Family
[☐] Marital Separation
[☐] Pending Marriage
[☐] Career Change
[☐] Taking on Debt
[☐] Major Health Change in Family
[☐] Other ______

Habit History (Circle your answer to each question)

Do you clench your teeth together under stress? ☐ Yes ☐ No ☐ Don't Know

Do you grind/ clench your teeth at night? ☐ Yes ☐ No ☐ Don't Know

Do you sleep with an unusual head position? ☐ Yes ☐ No ☐ Don't Know

Are you aware of any habits or activities that may aggravate this condition? ☐ Yes ☐ No ☐ Don't Know

Describe ______

Symptoms (Circle each symptom that applies)

Head Paid, 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 with/without shooting pain)
Hair and/or Scalp Painful to Touch

Throat Problems

Swallowing Difficulties
Tightness of Throat
Sore Throat
Voice Fluctuations
Laryngitis
Frequent coughing/Clearing Throat
Feeling of Foreign Object in Throat
Tongue Pain
Salivation
Pain in the Hard Palate

Teeth and Gum Problems

Clenching, Grinding at night
Looseness and/or Soreness of Back Teeth
Tooth Pain

Jaw and Joint (TMD) Problems

Clicking, Popping Jaw Joints
Grating Sounds
Jaw Locking opened or Closed
Pain in Cheek Muscles
Uncontrollable Jaw/Tongue Movements

Neck and Shoulder Pain

Reduced Mobility and Range of Motion
Stiffness
Neck Pain
Tired, Sore Neck Muscles
Back Pain, Upper or Lower Shoulder Aches
Arm and Finger Tingling, Numbness

Pain, Ear Problems, Postural Imbalances

Hissing, Buzzing, or Ringing
Ear Pain without Infections
Clogged, Stuffy, Itchy Eats
Balance Problems – "Vertigo"
Diminished Hearing

Mouth, Face, Cheek, and Chin Problems

Discomfort
Limited Opening

Eye Pain or Ear Orbital Problems

Eye Pain – Above, Below, or Behind
Bloodshot Eyes
Blurring of Vision
Bulging Appearance
Pressure behind the Eyes
Light Sensitivity
Watering of the Eyes
Drooping of the Eyelids

Other ______

______