TMJ PATIENT INFORMATION

OFFICE USE ONLY

Patient ID: __ __ __ **Date:** __ __/__ __/ 20__ __ (month / day / year)

Site: ❑ UIHC ❑ CC **Visit #:** __ __

1. Are you...
   1❑ Male 2❑ Female?

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

3. What is your date of birth? __ __/__ __/19__ __ (month / day / year)

4. What is your race?
   1❑ American Indian 3❑ Black or African American 5❑ Mixed Race
   2❑ Asian or Pacific Islander 4❑ Hispanic 6❑ White

5. Please check your highest educational level:
   1❑ Some High School 3❑ Some College 5❑ Post Graduate Degree
   2❑ High School Diploma 4❑ College Degree 6❑ Professional School

6. What is your occupation? _____

7. Please check the box that applies.
   1❑ Single 2❑ Married/living with partner 3❑ Divorced 4❑ 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?
    1❑ No 2❑ Yes

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

    1❑ DC (Chiropractor) .....Date last seen? __ __/__ __ __ __ (month / year)

    2❑ DDS (Dentist).....Date last seen? __ __/__ __ __ __ (month / year)

    3❑ Other (please specify)_____ Date last seen? __ __/__ __ __ __ (month / year)

12. Do you take any medications for your TMJ symptoms?
    1❑ No 2❑ Yes

    12a. If "**Yes**," Please list:

    Prescription Medications

    _____

    _____

    Non-Prescription Medications

    _____

    _____

TMJ PATIENT QUESTIONNAIRE

OFFICE USE ONLY

Patient ID: _ _ _ _

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: ❑ UIHC ❑ 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❑	1❑	2❑	3❑	4❑
2. Does it hurt when you chew, or use the jaws?	0❑	1❑	2❑	3❑	4❑
3. Does it hurt when you are not chewing or using the jaws?	0❑	1❑	2❑	3❑	4❑
4. Is your pain worse on waking?	0❑	1❑	2❑	3❑	4❑
5. Do you have pain in front of the ear or ear aches?	0❑	1❑	2❑	3❑	4❑
6. Do you have jaw muscle (cheek) pain?	0❑	1❑	2❑	3❑	4❑
7. Do you have pain in the temples?	0❑	1❑	2❑	3❑	4❑
8. Do you have pain or soreness in the teeth?	0❑	1❑	2❑	3❑	4❑

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❑	1❑	2❑	3❑	4❑
2. Do you find it difficult to open your mouth wide?	0❑	1❑	2❑	3❑	4❑
3. Does your jaw ever get stuck (lock) as you open it?	0❑	1❑	2❑	3❑	4❑
4. Does your jaw ever lock open so that you cannot close it?	0❑	1❑	2❑	3❑	4❑
5. Is your bite uncomfortable?	0❑	1❑	2❑	3❑	4❑
6. Do you ever bite the inside of your cheeks, lips, or tongue?	0❑	1❑	2❑	3❑	4❑
7. Do you clench or grind your teeth while you are awake?	0❑	1❑	2❑	3❑	4❑
8. Do you clench or grind your teeth while you are asleep?	0❑	1❑	2❑	3❑	4❑

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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Visit #: __ __

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