TMJ SCREENING QUESTIONNAIRE

Form TMJSQ

This questionnaire was designed to provide important facts regarding the history of your condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

TODAY'S DATE: ___________________

☐ MR. ☐ MS ☐ MISS NAME: ______________________________
☐ MRS. ☐ DR. FIRST MIDDLE INITIAL LAST

AGE: ________________ DATE OF BIRTH: ____________ ☐ Male ☐ Female

ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

HOW LONG AT CURRENT ADDRESS? ________ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: ______________________________

EMPLOYED BY: ______________________________

ADDRESS: ______________________________

SS#: ______________ HOME PHONE: ________________ WORK PHONE: ______________

CELL PHONE ________________ EMAIL: ______________________________

RESPONSIBLE PARTY: ______________________________

FAMILY PHYSICIAN ______________________________

ADDRESS ______________________________

REFERRED BY: ______________________________

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

____ Head pain
____ Facial pain
____ Jaw clenching at night
____ Neck pain
____ Difficulty speaking
____ Difficulty swallowing
____ Snoring
____ Limited opening, jaw locking
____ Poor sleep
____ Feeling restless when laying down
____ Waking up frequently
Other:______________________

Additional symptoms I experience with headaches:

☐ Nausea
☐ Light sensitivity
☐ Noise sensitivity
☐ Dizziness
☐ Blurred vision
☐ Fatigue (he/she must lie down during these episodes)

HISTORY OF PRESENT ILLNESS

Have you been medically diagnosed with (check all that apply):

Y☐ N☐ Migraine Headaches
Y☐ N☐ Tension Headaches
Y☐ N☐ Sleep Apnea

Y☐ N☐ Do you have nasal congestion?

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

KEY: L= Left R=Right B=Both sides

	SEVERITY			FREQUENCY			DURATION				
	MILD	MODERATE	SEVERE	OCCASIONAL	FREQUENT	CONSTANT	SECONDS	MINUTES	HOURS	DAYS	WEEKS
L R B Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature ______________________________

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DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

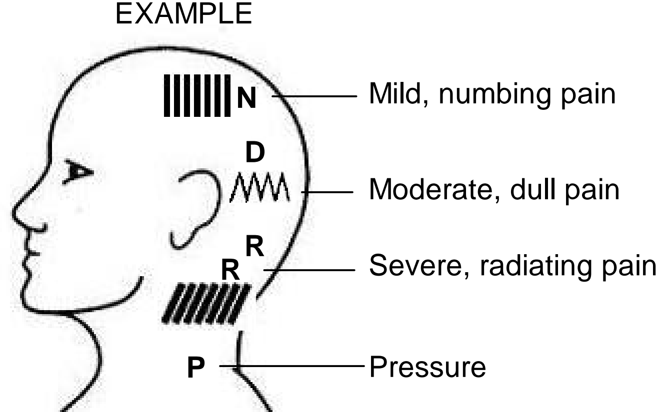
MILD PAIN

MODERATE PAIN

SEVERE PAIN

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

EXAMPLE



RIGHT

RIGHT LEFT

LEFT RIGHT

RIGHT

LEFT

Patient Signature ____

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