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**TMJ Questionnaire**

Do you have jaw joint pain, clinically known as temporomandibular joint (TMJ) pain? No \_\_ Yes \_\_Is the pain? Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Do you have TMJ noises when you open and close your mouth? No \_\_\_\_ Yes \_\_\_\_

Are the noises? Clicking \_\_\_\_ Popping \_\_\_\_ Grinding \_\_\_\_

Are the noises? Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Is the pain in the TMJ on the Left \_\_\_\_ Right \_\_\_\_

Are the TMJ noises on the Left \_\_\_\_ Right \_\_\_\_

When did your jaw joint problems (i.e., pain, noises, headache) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What started your jaw joint problems? Injury \_\_\_\_ Disease \_\_\_\_ Unknown \_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous TMJ surgery? No \_\_\_\_ Yes \_\_\_\_

Has your jaw alignment or bite changed? No \_\_\_\_ Yes \_\_\_\_

How much change? Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Do you get headaches? No \_\_\_\_ Yes \_\_\_\_

Are the headaches: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Are your headaches worse in the: Morning \_\_\_ Afternoon \_\_\_ Evening \_\_\_ Night \_\_\_ No Difference \_\_\_\_

How many headaches do you get? a week \_\_\_\_ a month \_\_\_\_

Are they: Occasional \_\_\_\_ Frequent \_\_\_\_ Constant \_\_\_\_

Where do the headaches occur? Left Forehead \_\_\_ Right Forehead \_\_\_ Left Temple \_\_\_ Right Temple \_\_\_ Back of the Head \_\_\_ Top of Head \_\_\_ Behind Left Eye \_\_\_Behind Right Eye \_\_\_

Do you have pain elsewhere? Neck \_\_\_\_ Shoulder \_\_\_\_ or Back pain \_\_\_\_ Is the pain: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Do you clench \_\_\_\_ and/or grind \_\_\_\_ your teeth at night? No \_\_\_\_ Yes \_\_\_\_

During the day? No \_\_\_\_ Yes \_\_\_\_

Is your clenching/grinding: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Do you get earaches? No \_\_\_\_ Yes \_\_\_\_ On which side? Left \_\_\_\_ Right \_\_\_\_ Are they: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Do they occur: Occasionally \_\_\_\_ Moderately \_\_\_\_ Frequently \_\_\_\_ Continuously \_\_\_\_

Do you get ringing in your ears? No \_\_\_\_ Yes \_\_\_\_

Is the ringing: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

Does it occur: Occasionally \_\_\_\_ Moderately \_\_\_\_ Frequently \_\_\_\_ Continuously \_\_\_\_

Do you get lightheadedness or dizziness? No \_\_\_Yes \_\_\_\_ Is it Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_\_\_

Does it occur: Occasionally \_\_\_\_\_ Moderately \_\_\_\_ Frequently \_\_\_\_ Continuously \_\_\_\_

Do you suffer from anxiety and/or depression? No \_\_\_\_ Yes \_\_\_\_

Are you under treatment for anxiety and/or depression? No \_\_\_\_ Yes \_\_\_\_

Do you have problems with other body joints? No \_\_\_\_ Yes \_\_\_\_ Please list the other joints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle the number that best describes your jaw situation:

Temporomandibular Joint (TMJ) Pain

(No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Headache

(No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Average daily pain for head and neck area

(No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Rate your jaw function for opening, side to side movement, and chewing

Function Normal 0—1—2—3—4—5—6—7—8—9—10 No Function (Jaws Frozen )

What can you chew?

No Restriction (Chew Anything) 0—1—2—3—4—5—6—7—8—9—10 Liquids Only (Cannot Chew)

How much does your jaw problem affect your ability to carry out normal life activities?

No Interference in Any Way 0—1—2—3—4—5—6—7—8—9—10 Totally Disabled