Version: TMDQV1

# TMJ Screening Consultation

OFFICE USE
Patient ID:

NAME: _____ CURRENT DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

**Referring Physician:** Contact ID:

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

1. Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

2. Then rate your complaints for frequency and intensity:

**Frequency**
1-SELDOM 2-OCCASIONAL 3-FREQUENT 4-EVERYDAY

**Intensity**
0=NO PAIN and 10 is MOST SEVERE PAIN

| Number #1 = the most severe symptom | | Frequency 1-4 | Intensity 1-10 | Number #1 = the most severe symptom | | Frequency 1-4 | Intensity 1-10 |
|---|---|---|---|---|---|---|---|
| ☐ | Jaw pain | ☐ | ☐ | ☐ | Migraines | ☐ | ☐ |
| ☐ | Jaw clicking | ☐ | ☐ | ☐ | Morning head pain | ☐ | ☐ |
| ☐ | Jaw locking | ☐ | ☐ | ☐ | Ringing in the ears | ☐ | ☐ |
| ☐ | Limited mouth opening | ☐ | ☐ | ☐ | Dizziness | ☐ | ☐ |
| ☐ | Facial pain | ☐ | ☐ | ☐ | Nocturnal teeth grinding | ☐ | ☐ |
| ☐ | Neck pain | ☐ | ☐ | ☐ | Frequent Heavy Snoring | ☐ | ☐ |
| ☐ | Headaches | ☐ | ☐ | ☐ | Pain when chewing | ☐ | ☐ |

Other: Write In

## Symptoms

### HEAD PAIN

☐ Entire head (Generalized)

☐L ☐R ☐B Front of your head (Frontal)

☐ Top of the head

☐L ☐R ☐B Back of your head

☐L ☐R ☐B In your temples

### JAW PAIN

☐L ☐R ☐B Jaw pain - on opening

☐L ☐R ☐B Jaw pain - while chewing

☐L ☐R ☐B Jaw pain - at rest

### JAW SYMPTOMS

☐ Jaw popping

☐L ☐R ☐B Jaw clicking

☐ Jaw locks closed

☐ Jaw locks open

☐ Teeth grinding

### MOUTH AND NOSE RELATED CONDITION

☐ Burning tongue

☐ Frequent biting of cheek

☐ Frequent snoring

☐ Broken teeth

☐ Teeth clenching

☐ Dry mouth

Patient Signature: Date:

# Symptoms

### EAR RELATED CONDITIONS

- ☐ Buzzing in the ears
- ☐ Tinnitus (ringing in the ears)
- ☐ Ear pain
- ☐ Ear congestion
- ☐ Pain in front of the ear
- ☐ Hearing loss
- ☐ Recurrent ear infections
- ☐ Pain behind the ear

### EYE RELATED CONDITIONS

- ☐ Blurred vision
- ☐ Eye pain
- ☐ Pain or pressure behind the eyes

### THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

- ☐ Back pain - lower
- ☐ Back pain - middle
- ☐ Back pain - upper
- ☐ Chronic sore throat
- ☐ Constant feeling of a foreign object in throat
- ☐ Difficulty in swallowing
- ☐ Limited movement of neck
- ☐ Neck pain
- ☐ Numbness in the hands or fingers
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder pain
- ☐ Shoulder stiffness
- ☐ Swelling in the neck
- ☐ Swollen glands
- ☐ Thyroid enlargement
- ☐ Tightness in throat
- ☐ Tingling in the hands or fingers
- ☐ Chronic sinusitis

Other

Patient Signature: Date:

# History Of Symptoms

When did the pain or condition first occur?

Is there anything that makes your pain or discomfort worse?

What do you believe is the cause of the pain or condition

- ☐ a motor vehicle accident
- ☐ a motorcycle accident
- ☐ a work related incident
- ☐ a playground incident
- ☐ an athletic endeavor
- ☐ a fight
- ☐ a fall
- ☐ an accident
- ☐ an illness
- ☐ an injury
- ☐ orthodontics
- ☐ dental procedures
- ☐ whiplash
- ☐

Other

Is there anything that makes your pain or discomfort better?

What other information is important regarding the pain or condition?

# History Of Treatment

| Practitioner's Name | Specialty | Treatment | Approximate Date |
|---|---|---|---|
| | | | |
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# Head Pain History

**Pain Qualities**

--- LOCATION ---

Which side are the headaches worse?

- ☐ both sides
- ☐ the left side
- ☐ the right side
- ☐

Patient Signature:

Date:

# Head Pain History

**Pain Qualities**

--- LOCATION ---

Headache spreads to

- ☐ the temple
- ☐ the back of the head
- ☐ the temple
- ☐ the back of the head
- ☐ the forehead
- ☐ _____

--- SEVERITY ON A SCALE OF 0-10 ---

--- 0=No Pain 10=Worst Pain Imaginable ---

_____ Jaw Pain on a Numeric Pain Scale

_____ Headaches on a 0-10 Pain Scale

_____ Neck Pain on a Numeric Pain Scale

_____ Facial Pain on a 0-10 Pain Scale

FREQUENCY

- ☐ occasional (0-3/mo)
- ☐ frequent (3-6/mo)
- ☐ constant
- ☐ _____

--- DURATION ---

- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Weeks

**When having pain do you experience:**

- ☐ Dizziness
- ☐ Double vision
- ☐ Fatigue
- ☐ Nausea
- ☐ Sensitivity to light (photophobia)
- ☐ Sensitivity to noise
- ☐ Throbbing
- ☐ Vomiting
- ☐ Burning

Other _____ _____

Patient Signature: _____ Date: _____

# DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

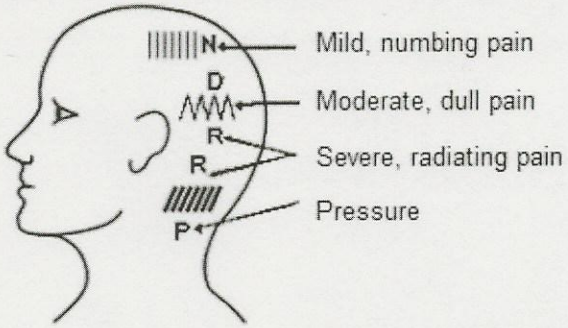
**DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:**

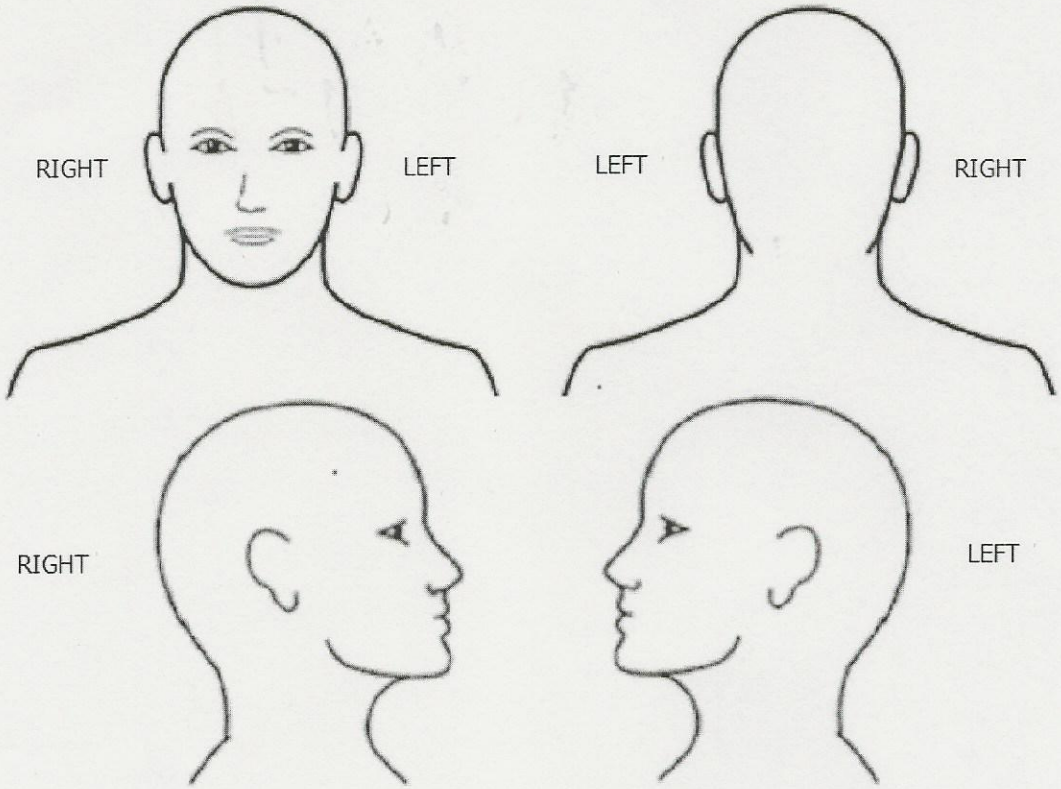
MILD PAIN |||||||

MODERATE PAIN ^^^^

SEVERE PAIN ////////

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




Enter any text to appear below the image:

## Patient Signature

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 charges for treatment to me regardless of insurance coverage.

Patient Signature: Date:

I certify that the medical history information is complete and accurate.

Patient Signature: Date: