

THE INTERNATIONAL PARTNERSHIP FOR THE STUDY OF OCCLUSION

Today's Date _____

SUPPLEMENTAL TMJ QUESTIONNAIRE

Name _____	Birthday _____
Address _____	
Name and address of person responsible for payment of services rendered: _____	
Medical Insurance Company _____	Group # _____
Provided through _____ (Employer, Labor Union, Association)	
Family Member Primarily Insured _____	SS# _____
Relationship to Patient _____	

What is your primary complaint? _____

How long have you noticed this? _____

- | | | | | |
|--|---------------------------------|-------------------------------------|---------------------------------------|-----------------------------|
| Do you jaw joints hurt? | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> Right | <input type="checkbox"/> No |
| Do your jaw joints make popping noise? | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> Right | <input type="checkbox"/> No |
| Do your jaw joints make grating noises? | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> Right | <input type="checkbox"/> No |
| Do you have difficulty moving or opening your jaws? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did your jaw joints used to pop but now no longer do so? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been made aware of clenching or grinding your teeth at night? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are your teeth or jaws sore or tired when you awaken? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you clench or grind your teeth during the day? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have ringing in your ears? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have earaches? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any pain in your facial muscles? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have headaches? | <input type="checkbox"/> Always | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally | <input type="checkbox"/> No |
| Do you have neckaches? | <input type="checkbox"/> Always | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally | <input type="checkbox"/> No |
| Have you ever worn a dental appliance to improve your bite? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had a whiplash injury to your neck? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had trauma to your head? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have arthritis in any of your joints? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Which joints? _____

What type of arthritis? Osteoarthritis Rheumatoid _____

Arthritis medications? _____

Do you suspect that your arthritis also involves your jaw joints? Yes No

Are you currently under a great deal of stress? Yes No

Please list chronologically all health professionals you have seen for this problem.

Date	Name	Type of Practitioner	Treatment	Result

Please list all medications you have taken for this problem.

Medication	Prescribed By	Date	Results