Orofacial Pain & TMJ
Screening Questionnaire

Name   Date   Age

In your own words, please explain why you are here:

Date problem began: _____________   Age problem began: ___________
Previous facial injury? Yes___ No___   If so, when was the injury? ________________
Please give details of the injury:

Please check if you had any of the following:

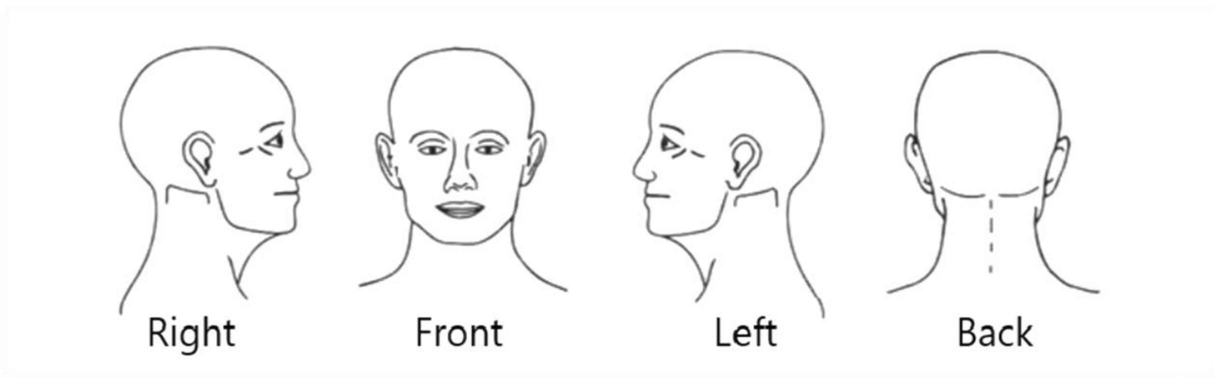
		When?		Results: Good	Fair	Poor
☐	Orthodontics	When?	_________			
☐	Occlusal adjustment	When?	_________			
☐	Physical therapy	When?	_________			
☐	TMJ splint	When?	_________			
☐	TMJ arthroscopic surgery	When?	_________			
☐	TMJ open joint surgery	When?	_________			
☐	TMJ closed joint surgery	When?	_________			

Medications taken in the past for TMJ: ______________________________
Current medications for TMJ: ______________________________

Indicate on the following scale how severe your pain is the majority of the time

0 No pain   1   2   3   4   5   6   7   8   9   10 Severe pain

Please indicate where you are having pain on the diagram below



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Is the pain constant or intermittent? (circle one)

Does it hurt to move your jaw? Yes ____ No____

Does it hurt to chew? Yes____ No____

Does the pain/problem limit your function? Yes____ No____

If so, how?____

When is the pain worse? (circle one) Morning Afternoon Evening

Other time: ____

Does anything you do make the pain worse?

____

Does anything you do make the pain better?

____

What other doctors or health care associates have you seen regarding this pain/problem?

Does your jaw ever lock open? ________ closed? _________

How has this been treated? ____

Can you do anything to prevent or treat this? ____

Do you grind or grit your teeth? Yes____ No____

Do you have or have you had any of the following? (circle all that apply)

Sinus Problems Hearing Changes Stressful Job Sensitive Teeth Ringing in Ears

Marital Problems Periodontal Disease Dizziness Trouble Sleeping Headaches

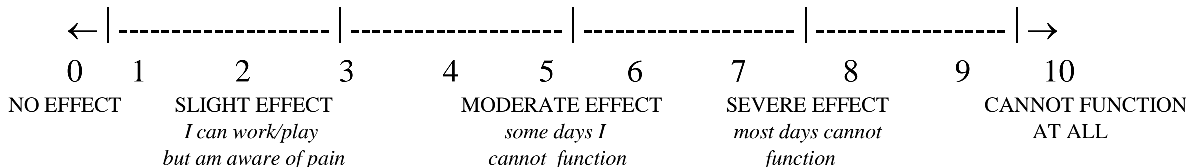
Shoulder Pain Ulcers Migraines Arthritis Nervous Stomach Neck Ache Allergies

Skin Disease Earache Depression - to what? __________________________

List other medical problems: ____

____

The pain is having this effect on my life



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