

PTFW

Business Office

Phone: 817-247-1130

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Treatment Locations:

Fort Worth

Dallas

Colleyville

TMJ QUESTIONNAIRE

Patient _____ DOB _____ Today's Date _____

Please check yes or nor to the following questions and describe when indicated. This will help us understand your present and past medical history. This information will maximize the safety and effectiveness of your evaluation and/or treatment and is strictly confidential.

GENERAL MEDICAL HISTORY

- | | | |
|--|------------------------------|-----------------------------|
| Do you have pain on opening your mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain on closing your mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain in the fully opened position? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain biting a firm object? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain with eating? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain with chewing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Right___ Left ___ Both ___ | | |
| Do you have stiffness on waking, pain with function that decreases as the day goes by? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain with a yawn? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain when biting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain with chewing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain with swallowing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain with speaking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have pain with shouting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you breathe through your nose? | | |
| Do you breathe through your mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any clicking of your jaw? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your mouth or jaw ever locked? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Open___ Closed___ | | |
| Do you have any of the following habits? | | |
| Pipe smoking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Using a cigarette holder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leaning on your chin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chewing gum? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Biting nails? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chewing hair? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pursing and chewing lips? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Continually moving mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other nervous habits? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you grind your teeth or hold them tightly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are any teeth missing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, which ones? _____ | | |
| Are any teeth painful or sensitive? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you hold your head in any particular posture? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you noticed any voice changes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you wear a dental splint? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you seen a dentist? Yes No

If yes, what were the results? _____

Are there any activities/hobbies/self-care/or work related duties that you are unable to perform? Yes No

Have you ever had surgery? Yes No
If so, tell when, what type, and outcome _____

How do you think you learn best? (Check all that apply)

- Seeing (reading written material or viewing i.e., booklet, brochure, slides, video, pictures)
- Listening (tape, lecture, or presentation)
- Doing (by actually performing the activity or doing the task)
- Not sure

Attitude Towards Problem

- No problem
- Minor inconvenience
- Slight problem
- Moderate problem
- Major problem

Confidence in Controlling Your Problem

- Complete confidence
- Moderate confidence
- Little confidence
- No confidence

What goals do you hope to achieve in this program? _____

List any other information that you feel would be helpful on your evaluation: _____

Signature _____ Date _____