TMJ Questionnaire

Westside ORTHODONTICS

Today's Date:_____

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr. ☐ Male ☐ Female

Name:_____

Age:_____ Date of Birth:_____

Address:_____

City/State/Zip:_____

Employed By:_____

Address:_____

SS#:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Email:_____

Responsible Party:_____

Physician Name & Address: _____

_____

Referred By: _____

List any medications which have caused an allergic reaction

Y	N	Antibiotics	Y	N	Metals
Y	N	Aspirin	Y	N	Penicillin
Y	N	Codeine	Y	N	Plastic
Y	N	Iodine	Y	N	Sedatives
Y	N	Latex	Y	N	Sleeping pills
Y	N	Local anasthetics	Y	N	Sulfa drugs

Other allergens:

_____

_____

_____

What are the chief complaints for which you are seeking treatement?

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

2. Then rate your complaints for frequency and intesiy:

Frequency:
(1 - Selcome, 2 - Occasional, 3 - Frequent, 4 - Every Day)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN

Number	Frequency	Intesity
#1 = the most severe symptom	1-4	0-10
____ Back Pain	____	____
____ Dizziness	____	____
____ Ear Congestion	____	____
____ Ear Pain	____	____
____ Eye Pain	____	____
____ Facial Pain	____	____
____ Fatigue	____	____
____ Headaches	____	____
____ Jaw Clicking	____	____
____ Jaw Joint Noises	____	____
____ Jaw Locking	____	____
____ Jaw Pain	____	____
____ Limited Mouth Opening	____	____
____ Muscle Soreness	____	____
____ Muscle Twitching	____	____
____ Neck Pain	____	____
____ Pain when Chewing	____	____
____ Ringing in the Ears	____	____
____ Shoulder Pain	____	____
____ Sinus Congestion	____	____
____ Throat Pain	____	____
____ Visual Disturbances	____	____
____ Other:_____	____	____

Patient Signature: _____ Date:_____

"If excellence is available,
GOOD IS NOT ENOUGH"

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Employed By:_____

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Work Phone:_____ Cell Phone:_____

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Responsible Party:_____

Physician Name & Address: _____

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Referred By: _____

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____ Visual Disturbances	____	____
____ Other:_____	____	____

Patient Signature: _____ Date:_____

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