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Patient Information

Mr. / Mrs. / Ms.

First Name:_____ Last Name:_____

D.O.B.:_____ Email:_____

Address:_____ Postal Code:_____

Home #:_____ Cell #:_____ Work #:_____

Whom may we thank for referring you to our office?_____

Date of Questionnaire:_____

TMJ Questionnaire

Do you wake with morning headaches?	Y	N
Do you develop a headache about 10 or 11am?	Y	N
Have you been told your headaches are due to tension?	Y	N
Do you find yourself clenching your teeth?	Y	N
Do you have difficulty opening your mouth?	Y	N
Does your jaw get “stuck”, “locked”, or “go out”?	Y	N

Do you have pain around the ears or cheeks?. . . . . Y N

Do you have pain on chewing, yawning, or wide opening?. . . . . Y N

Does your bite feel uncomfortable or unusual?. . . . . Y N

Have you ever had an injury to your jaw, head, or neck?. . . . . Y N

Have you ever had arthritis?. . . . . Y N

Have you previously been treated for a Temporomandibular (TMJ) Disorder? Y N

If so, when and by whom?_____

_____

_____

Signatures

Patient/Guardian Signature:_____

Date:_____

For Office Use Only

Notes/Comments/TX Plan:

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