

TMJ/Facial Pain History

Date: _____

Patient name: _____ Date of Birth: _____

How did you get referred to our practice? Dentist _____ Physician _____
 Internet Friend

What type of clinicians have treated your head and neck symptoms? physical therapist TMJ specialist
 pain clinic oral surgeon orthodontist general dentist ENT neurologist

What type of treatment have you had for your head and neck symptoms? splint TMJ arthrocentesis
 TMJ surgery occlusal reconstruction braces physical therapy jaw surgery other

How do you control your head and neck symptoms?

cold/heat packs physical therapy diet change anti-inflammatory medication pain medication
 limited jaw movement other

I have the following habits: grinding during sleep clenching biting nails chewing gum

Have you had injury to your face, head, neck or jaw? Y N

Are you in an emotional or stressful period in your life? Y N

Are any of your arms, legs, feet, hands or finger joints painful, swollen or stiff? Y N

Have you ever taken steroid medications? Y N

Have you had any recent changes in your bite? Y N

Facial Pain History

How long have you been suffering with facial pain? _____ years _____ months

My pain is intermittent constant

The pain is worse in the morning afternoon evening

The pain limits my eating speaking sleeping life in general

My diet is: normal without pain normal with some pain normal with moderate amount of pain
 soft foods only I am mostly on liquids

My pain is localized:

- Right in my ears above my ears below my ears in front of my ears
 Left in my ears above my ears below my ears in front of my ears

Circle on photo your area(s) of pain (be as specific as possible):



On a scale of 1 to 10, how would you rate your pain (circle one number)...

- Most of the time (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)
At its worst (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)
At its least (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Disc History

What sounds do you hear in your joints when you open and close your mouth?

- Popping R L does not apply
 Clicking R L does not apply
 Grinding R L does not apply

Has the size of your mouth opening decreased?

- R L does not apply

Have you ever been stuck open and unable to close your mouth?

- R L does not apply

If yes, how many times? 1 time 2 times 3 times ≥ 4 times

Have you ever been stuck closed and unable to open your mouth?

- R L does not apply

If yes, how many times? 1 time 2 times 3 times ≥ 4 times

Please use the space below to describe your problem in your own words and previous treatments:

Patient Name: _____ Date: _____