TMJ PATIENT PROFILE

Name: _____ Date: _____

Age: _____ Referred by: _____

How long have you had TMJ pain? _____
Describe the problem in your own words:

Which side hurts?: _____Right _____Left _____Both
Is the pain worse in the afternoon? _____ Worse in the morning? _____

Is the pain: ___Constant ___Aching ___Burning ___Stabbing ____Other—describe:

Do you have any of the following:

YES	NO	
_____	_____	Headaches
_____	_____	Neck Pain
_____	_____	Jaw Pain
_____	_____	Ear Pain
_____	_____	Face Pain
		Other—describe:
_____	_____	Does it hurt to chew ?
_____	_____	Does it hurt to open wide ?
_____	_____	Does your jaw make a popping noise ?
_____	_____	Does your jaw make a clicking noise ?
_____	_____	Does your jaw make a grinding noise ?
		Other—describe
_____	_____	Has your jaw ever "locked" or slipped out of place ?
_____	_____	Do you ever clench or grind your teeth ?
_____	_____	Do you have problems with your ears ? ___ Hearing ___Dizziness
		Other—describe
_____	_____	Is it difficult to swallow ?
_____	_____	Is it painful to swallow ?
_____	_____	Are your teeth sore or sensitive ?
_____	_____	Are you taking medication of any kind ? IF YES—list