TMJ SCREENING QUESTIONNAIRE

Form TMJSQ

This questionnaire was designed to provide important facts regarding the history of your condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

TODAY'S DATE: _____

☐ MR. ☐ MS ☐ MISS ☐ MRS. ☐ DR. NAME: _____ (FIRST / MIDDLE INITIAL / LAST)

AGE: _____ DATE OF BIRTH: _____ ☐ Male ☐ Female

ADDRESS: _____

CITY/STATE/ZIP: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE _____ EMAIL: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN _____

ADDRESS _____

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

___ Head pain
___ Facial pain
___ Jaw clenching at night
___ Neck pain
___ Difficulty speaking
___ Difficulty swallowing
___ Snoring
___ Limited opening, jaw locking
___ Poor sleep
___ Feeling restless when laying down
___ Waking up frequently
Other: _____

Additional symptoms I experience with headaches:

☐ Nausea ☐ Light sensitivity ☐ Noise sensitivity ☐ Dizziness ☐ Blurred vision ☐ Fatigue (he/she must lie down during these episodes)

HISTORY OF PRESENT ILLNESS

Have you been medically diagnosed with (check all that apply):

Y☐ N☐ Migraine Headaches
Y☐ N☐ Tension Headaches
Y☐ N☐ Sleep Apnea

Y☐ N☐ Do you have nasal congestion?

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

KEY: L= Left R=Right B=Both sides

		SEVERITY			FREQUENCY			DURATION				
		MILD	MODERATE	SEVERE	OCCASIONAL	FREQUENT	CONSTANT	SECONDS	MINUTES	HOURS	DAYS	WEEKS
L R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____