TMJ / Pain Questionnaire

Patient's Name: ____ Age: _______ Date: ____________________

Please indicate if you experiences or has experienced any of the symptoms below:

1. ______ Do you wake with headaches in the morning?
2. ______ Does your Jaw or face often feel sore or tired?
3. ______ Do you hear popping or clicking from your jaw joints?
4. ______ Has your jaw ever locked open or closed?
5. ______ Do you grind or clench your teeth?
6. ______ Have you had orthodontic treatment (Braces)?
7. ______ Do you experience pain on opening wide?
8. ______ Do you have ringing in the ears?
9. ______ Do you experience muscle tightness in neck, shoulders or upper back?
10. ______ Do you take over the counter or prescription medications more than 2x a week or head or face pain?
11. ______ Does pain limit your ability to do daily activities?