

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 NAME: _____

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

Additional symptoms I experience with headaches:

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Noise sensitivity | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue (he/she must lie down during these episodes) |

HISTORY OF PRESENT ILLNESS

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

Y <input type="checkbox"/> N <input type="checkbox"/>	Migraine Headaches
Y <input type="checkbox"/> N <input type="checkbox"/>	Tension Headaches
Y <input type="checkbox"/> N <input type="checkbox"/>	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
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

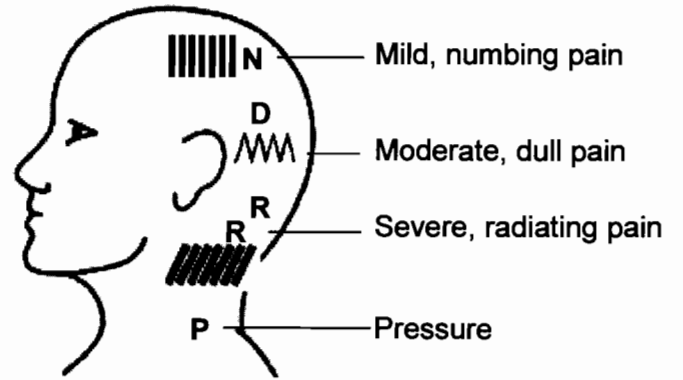
I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that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

Patient Signature _____

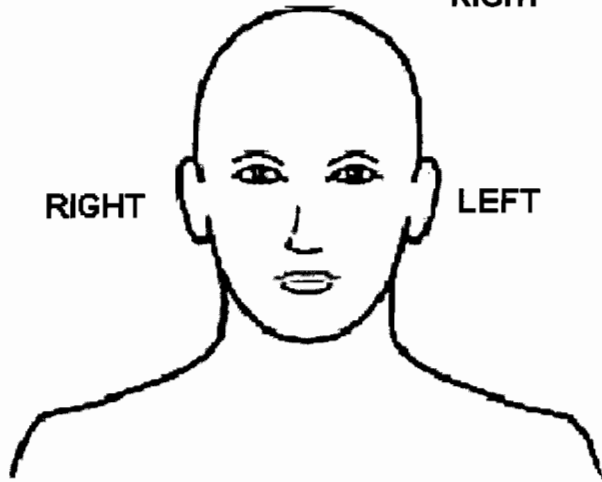
**DRAW YOUR PAIN PATTERNS
FOLLOWING THIS KEY:**

MILD PAIN		B Burning
		D Dull
		N Numbing
MODERATE PAIN		P Pressure
		S Sharp
		T Tingling
SEVERE PAIN		R Radiating

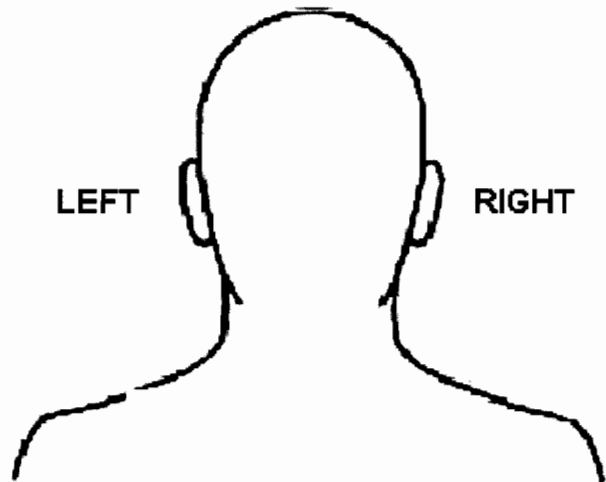
EXAMPLE



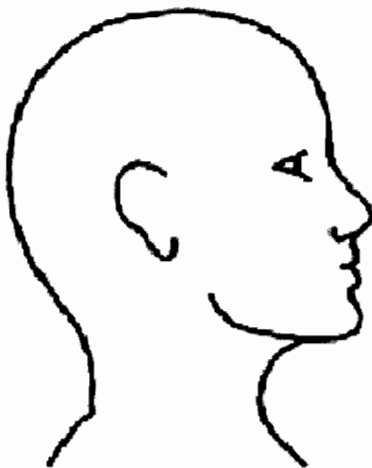
RIGHT



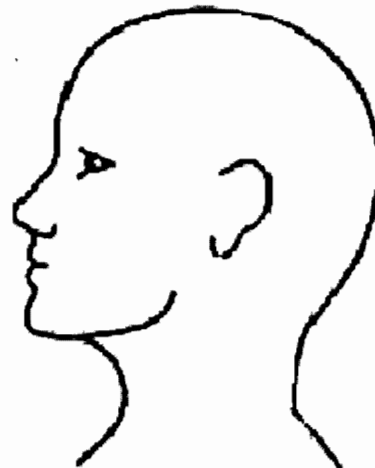
LEFT



RIGHT



LEFT



Patient Signature _____