Patient ___________________________________ DOB ________________ Date _____________________

Account # __________________________ Dr ____

TMD History

1. Chief Complaint: ____

2. Onset / Cause: (insidous / trauma / other) ________________________________

3. Location, frequency, and symptom characteristics:

Legend A. Frequency: C = Constant D = Daily W = Weekly M = Monthly

B. Symptom modified by: 1 = biting to eat 2 = opening mouth to eat 3 = talk 4 = yawn 5 = movement of jaw (unrelated to 1,2,3 or 4)

6 = parafunction (see #12) 7 = stress 8 = during sleep 9 = waking in AM 10 = sit 11 = exercise 12 = nothing

Location of symptom(s)			Frequency	Pain Intensity (0-10) curent	high	low	Symptom(s) modified by	X = H/A location Y = Migraine location Frequency of X / Y
Jaw	TMJ	R L						
	masseter	R L						
	temporalis	R L						
Ear	* pain * fullness * tinnitus	R L						
Face	* forehead * eyes	R L R L						
Head	* top of head * back of head	R L R L						
Neck	upper neck	R L						
	neck	R L						
	shoulder	R L						

Comments:

4. Do you hear a click (noise) when you move your jaw? Yes R L No **Used to click Yes R L No**

If yes: every time you move your jaw / most of the time / infrequent / very seldom

Do you have pain when you experience the click? Yes R L No

5. Do you hear a grinding noise when you move your jaw? Yes R L No

If yes: every time you move your jaw / most of the time / infrequent / very seldom

Do you have pain when you experience the grinding noise? Yes R L No

6. Does your jaw catch / lock even for a moment when opening? Yes R L No **Used to catch Yes R L No**

If yes, does it catch or intermittently lock: every time you open / most of the time / infrequent / very seldom

7. Do you have limited mouth opening? Yes No **Used to be limited Yes No**

8. Is your jaw "locked", severely limiting your ability to eat? Yes R L No **Used to be locked Yes R L No**

9. When you close from a wide open position, does your jaw catch / lock even for a moment? Yes R L No

If yes: every time you close from a wide open position / most of the time / infrequent / very seldom / used to

10. Is your jaw currently locked open? Yes R L No

11. Are you able to bring your back teeth together? Yes No R L

12. Parafunction Do you hold your teeth together, clench or grind your teeth? Yes No

Do you hold your jaw tight without teeth in contact? Yes No

Do you chew: gum ___ / ice ___ / finger nails ___ / inside of mouth ___ / other __________________

13. Have you seen other health care professionals for your symptoms? Yes No

If yes: Dentist / Oral Surgeon / PCP / ENT / Neurologist / Physcial therapist / Chiropractor / Massage therapist

Other: ____

Treatment consisted of: ____

Response to treatment: ____

Steve Kraus PT