Name:_____ Date:_____

In your own words, please describe the reason you are concerned about your jaw joints.

_____

_____

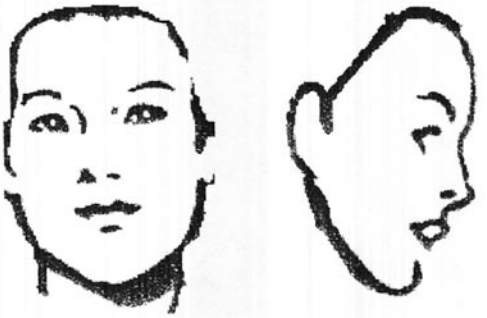
_____

_____

Please describe your stress level:_____

Please indicate if you are experiencing any of the following:

Facial Pain	YES	NO	If so, indicate where on diagram.
Jaw pain	YES	NO	If so, indicate where on diagram.
Neckaches	YES	NO	
Jaw soreness on waking	YES	NO	
Headaches on waking	YES	NO	
Eye Pain	YES	NO	
Ear Pain	YES	NO	
Pain While Eating	YES	NO	
Headaches	YES	NO	



If you answered yes to any of the questions above, please describe what type of discomfort you are experiencing, as well as the location and duration.

_____

_____

_____

_____

_____

_____

_____

Name:_____

Are you currently experiencing any of the following:

			Please comment as necessary.
Dizziness	YES	NO	_____
Lightheadedness	YES	NO	_____
Visual Disturbances	YES	NO	_____
Post Nasal Drainage	YES	NO	_____
Difficulty Swallowing	YES	NO	_____
Chronic Sore Throat	YES	NO	_____
Difficulty Opening Mouth	YES	NO	_____
Difficulty Closing Mouth	YES	NO	_____
Clicking of Jaw	YES	NO	_____
Ring/Buzz in Ears	YES	NO	_____
Facial Muscle Spasms	YES	NO	_____
Fractured Teeth	YES	NO	_____
Difficulty With Speech	YES	NO	_____

Have you been involved in a motor vehicle accident or sustained an injury to your jaw?

YES NO

If so, please give a date and a brief description of the accident/injury.

_____

_____

_____

_____

_____

_____

_____

Temporomandibular Joint Questionnaire

Name:_____

Have you ever been treated for jaw joint problems?

YES NO

If so, please give dates, description, and names of providers to the best of your recollection.

_____

_____

_____

_____

_____

To be completed by Dr. Widner.

ROM: Pain free opening _____ mm Passive stretch opening _____ mm

Maximum opening _____ mm Maximum protrusion _____ mm

Lateral - right _____ mm Lateral - left _____ mm

Deviation on opening:_____

Masticatory Muscle Exam (0=none, 1=slight, 2=moderate, 3=severe):

	RIGHT	LEFT
TMJ Lateral Capsule	_____	_____
Masseter	_____	_____
Temporalis	_____	_____
Medial Pterygoid	_____	_____
Lateral Pterygoid	_____	_____
Sternocleidomastoid	_____	_____
Posterior Cervical	_____	_____

Auscultation (0,1,2,3):	RIGHT	LEFT
Clicking/Popping	_____	_____
Crepitus	_____	_____
With Opening	_____ mm	_____ mm
With Closing	_____ mm	_____ mm

Occlusion: Class ___, Division ___ Vert. Overlap ___ mm Hor. Overlap ___ mm

Open Bite: Anterior Posterior

Crossbite: Anterior Posterior

Occlusal Wear: Slight Moderate Severe

Tooth Mobility: Slight Moderate Severe

Bruxism: Clenching Night Day Patient aware Denies