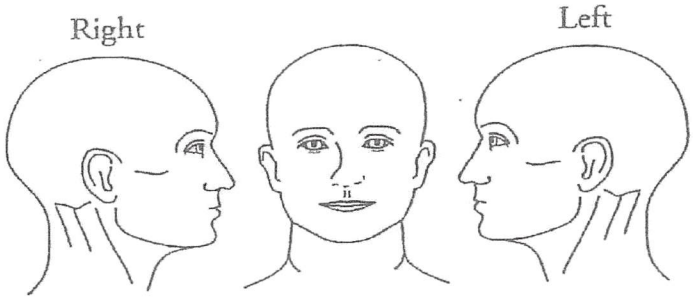
Jon M Van Slate, DDS,FAGD,LVIF

Initial Patient Questionnaire– TMJ/TMD Work-up

Name:_____ Date: _____

1. On the diagram, please shade the areas of your pain: Right ____ Left ____



2. When did your pain/problem begin?_____

3. What seemed to cause it to start?_____

4. What makes it feel worse?_____

5. What makes it feel better?_____

6. What treatments have you received?_____

7. When is your pain the worst?
- When first wake up___
- Later in the day ___
- No daily pattern ____
- Other ____
- Please explain (Other)_____

8. What does the pain keep you from doing?_____

9. Is your pain (check as many as apply)
- Ache _____
- Pressure_____
- Dull____
- Sharp_____
- Throbbing____
- Burning_____
- Other_____ Explain:_____

10. Does your pain:
- Awake you at night? Yes___ No ____
- Increase when you lie down? Yes____ No____
- Increase when you bend forward? Yes _____ No_____
- Increase when you drink hot or cold beverages? Yes _____ No_____

11. Please indicate 0-10 your present pain level, 10 being the worst pain imaginable:_____
12. Please indicate from 0-10 your average pain level during the past 6 months– O being no pain at all and 10 being the worst pain imaginable:_____
13. Is your pain always present? Yes_____ No_____ How often do you have pain?_____
_____
14. Please describe any symptoms other than pain that you associate with your problem
_____
_____
_____
_____
15. Have you had any of the following:
- Head or Neck Surgery? Yes ____ No____
- Whiplash or Trauma to your Head or Neck? Yes_____ No_____
- Shingles on your Head or Neck? Yes ____ No_____

16. Do you have any of the following:
- A fever? Yes____ No_____
- Nasal Congestion or Stuffiness? Yes_____ No_____
- Movement difficulties of facial muscles, eyes, mouth or tongue? Yes _____ No_____
- Numbness or Tingling? Yes_____ No_____
- Problems with your teeth? Yes_____ No_____
- Swelling over your jaw joint or in your mouth or throat? Yes_____ No_____
- A certain spot that triggers your pain? Yes _____ No_____
- Recurrent swelling or tenderness of joints other than in your jaw joint? Yes _____ No_____
- Morning Stiffness in your body, other than with your jaw? Yes_____ No_____
- Muscle tenderness in your body (other than in your head or neck) for more than 50% of the time? Yes_____ No_____

17. Is your problem worse:
- When swallowing or turning your head? Yes_____ No_____
- After reading or straining your eyes? Yes_____ No_____

18. Do your jaw joints make noise? Yes_____ No _____ If yes, which: Right_____ Left_____
19. Have you ever been unable to open your mouth wide? Yes_____ No_____
Please explain:_____
20. Have you ever been unable to close your mouth? Yes_____ No_____ If yes, please explain:_____
21. Do you sleep well at night? Yes_____ No_____ If no, please explain: _____
_____
22. How often are you tense, aggravated or frustrated during a usual day? Always _____ Never _____ Half the time _____ Seldom _____
23. How often do you feel depressed during a usual day? Always _____ Half the time_____ Seldom _____ Never _____
24. Do you have thoughts of hurting yourself or committing suicide? Yes_____ No _____

25. Do you play a musical instrument and/or sing more than 5 hours in a typical week? Yes _____ No_____
26. What percent of the day are your teeth touching? _____%
27. Are you aware of clenching or grinding your teeth:
- When Sleeping _____
- While Driving _____
- When using a computer_____
- Other times_____
- Not Aware _____

28. Are you aware of oral habits such as:
- Chewing your Cheeks _____
- Chewing Objects _____
- Biting your nails or cuticles_____
- Thrusting your jaw forward _____
- Other habits _____ Explain:_____
- Not Aware _____

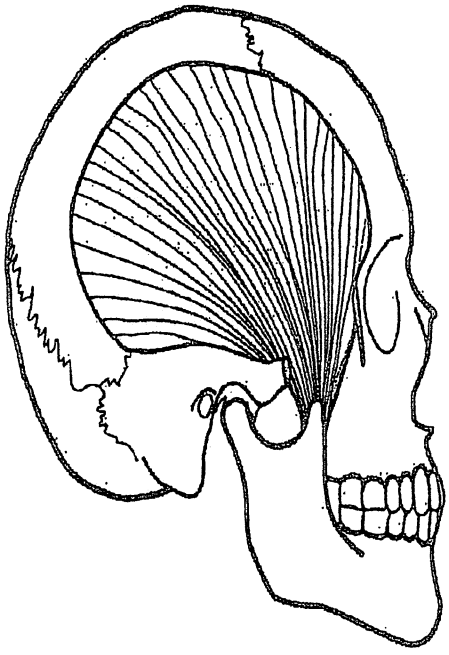
29. What treatment do you think is needed for your problem? _____
30. Is there anything else you think we should know about your problem? _____
_____
31. If your age is 50 or older, please circle the correct response:
- Does your pain occur only when you eat? Yes _____ No_____
- Are you pain free when you open wide? Yes_____ No_____
- Do you have unexplainable or unintentional weight loss? Yes_____ No_____
- Do you have significant morning stiffness lasting more than 1/2 hour? Yes_____ No_____
- Do you have visual symptoms or visual loss? Yes_____ No_____

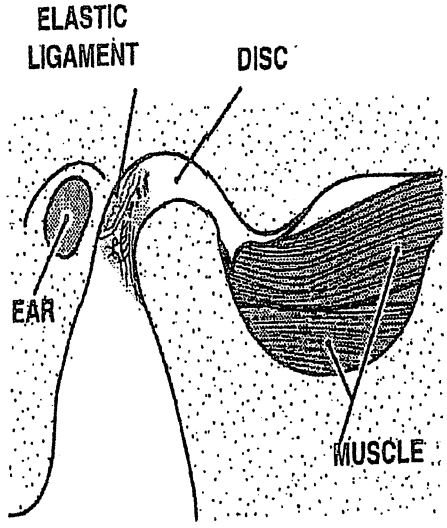
To the best of my knowledge, the above information is correct, and permission is granted for a written report to be sent to my referring and treating doctors and dentists.

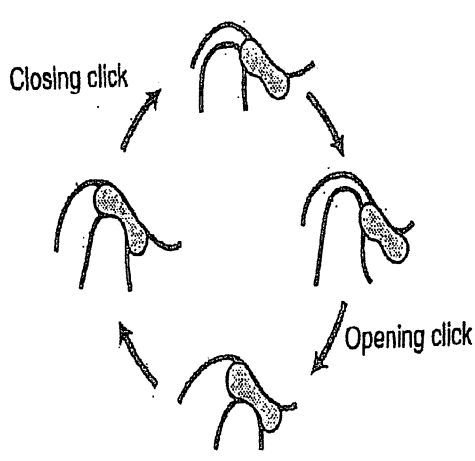
Signature_____ **Date**_____

Doctors Signature:_____**Date:**_____

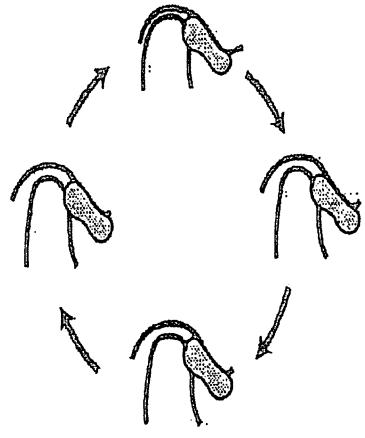
TMJ Disc Displacements







Clicking TMJ



Locking TMJ