# TMJ

Head, Neck and Facial Pain Questionnaire

*Please fill out form completely. Thank You*

*Please view this form in Google Chrome*

Date

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## PATIENT INFORMATION

| Patient's Name | | Phone Number<br>Home Work Cell | | |
|---|---|---|---|---|
| Street Address | | City | State | Zip |
| Age | Date of Birth | Gender<br>Male ☐ Female ☐ Other ☐ | Who may we thank for referring you? | |
| Family Physician | | Family Dentist | | |
| In Case of Emergency, Who Should be Notified? | | Relationship/Phone | | |

## PERSON RESPONSIBLE FOR ACCOUNT INFORMATION:

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ SS# _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____

## PRIMARY MEDICAL INSURANCE INFORMATION:*

Name of Insurance _____

Address _____

City _____ State _____ Zip _____

Name of Insured _____

Insured's Date of Birth _____

Insured's Employer _____

Policy/ID# _____ Effective Date _____

## SECONDARY MEDICAL INSURANCE INFORMATION:*

Name of Insurance _____

Address _____

City _____ State _____ Zip _____

Name of Insured _____

Insured's Date of Birth _____

Insured's Employer _____

Policy/ID# _____

***We do not participate with any medical insurance programs. Insurance information is for patient reimbursement purposes only.***

Signature of Patient, Parent, or Guardian _____ Date _____

Signature of Insured _____ Date _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
(Please order ***YOUR*** chief complaints by number, with "1" being most important)

| | | |
|---|---|---|
| _____ Back Pain | _____ Jaw Clicking | _____ Pain Behind Eyes |
| _____ Dizziness | _____ Jaw Joint Noises | _____ Pain When Chewing |
| _____ Ear Pain | _____ Jaw Locking | _____ Ringing in the Ears |
| _____ Ear/Sinus Congestion | _____ Jaw Pain | _____ Shoulder Pain |
| _____ Facial Pain | _____ Limited Mouth Opening | _____ Throat Pain |
| _____ Fatigue | _____ Muscle Twitching | _____ Tinnitis |
| _____ Headaches | _____ Neck Pain | _____ Visual Disturbances |
| _____ Inability To Open Mouth | Other _____ | |

LIST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING

| | Practitioner | Specialty | Treatment & Approx. Date |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ***ALLERGIC REACTION***

| | | |
|---|---|---|
| ☐ Antibiotics | ☐ Latex | ☐ Plastic |
| ☐ Aspirin | ☐ Local Anesthetics | ☐ Sedatives |
| ☐ Barbiturates | ☐ Metals | ☐ Sleeping Pills |
| ☐ Codeine | ☐ Penicillian | ☐ Sulfa Drugs |
| ☐ Iodine | Other Allergans _____ | |

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

| | | |
|---|---|---|
| ☐ Antibiotics | ☐ Cortisone | ☐ Nerve Pills |
| ☐ Anticoagulants | ☐ Diet Pills | ☐ Pain Medication |
| ☐ Barbiturates | ☐ Heart Medication | ☐ Sleeping Pills |
| ☐ Blood Thinners | ☐ Insulin | ☐ Sulfa Drugs |
| ☐ Codeine | ☐ Muscle Relaxants | ☐ Tranquilizers |
| Other _____ | | |

| | |
|---|---|
| ARE YOU PREGNANT? Yes ☐ No ☐ | IF YES, HOW FAR ALONG? |

**THIS SPACE FOR OFFICE USE:**

## MEDICAL HISTORY

- ☐ Adenoids
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Bleeding Easily
- ☐ Blood Pressure- High
- ☐ Blood Presure- Low
- ☐ Bruising Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Fatigue
- ☐ Cold Hands/Feet
- ☐ Current Pregnancy
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Thirst
- ☐ Fluid Retention
- ☐ Frequent Cough
- ☐ Frequent Illnesses
- ☐ Frequent Stressful Situations
- ☐ General Anesthesia
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay Fever
- ☐ Hearing Impairment

Other Medical/Dental History

- ☐ Heart Murmur
- ☐ Heart Disorder
- ☐ Heart Pacemaker
- ☐ Heart Palpitations
- ☐ Heart Valve Replacement
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypoglycemia
- ☐ Immune System Disorder
- ☐ Injury to Face
- ☐ Injury to Mouth
- ☐ Injury to Neck
- ☐ Injury to Teeth
- ☐ Insomnia
- ☐ Intestinal Disorders
- ☐ Jaw Joint Surgery
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Meniere's Disease
- ☐ Menstrual Cramps
- ☐ Multiple Sclerosis
- ☐ Muscle Aches
- ☐ Muscle Shaking (Tremors)
- ☐ Muscle Spasms or Cramps
- ☐ Muscular Dystrophy
- ☐ Needing Extra Pillows to Help Breathing at Night
- ☐ Nervous System Irritability
- ☐ Nervousness
- ☐ Neuralgia

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ Parkinson's Disease
- ☐ Poor Circulation
- ☐ Prior Orthodontic Treatment
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Slow-Healing Sores
- ☐ Snoring
- ☐ Speech Difficulties
- ☐ Stroke
- ☐ Swollen, Stiff or Painful Joints

Tendency For:

- ☐ Ear Infections
- ☐ Frequent Colds
- ☐ Sore Throats
- ☐ Tired Muscles
- ☐ Tonsils Removed
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Urinary Disorders
- ☐ Wisdom Teeth (3rd Molar) Extraction
- ☐ Yeast Infections

SYMPTOMS

*L=Left R= Right B= Both Sides*

### Head Pain

| | Location | Severity | | | Frequency | | | Duration | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | MILD | MODERATE | SEVERE | OCCASIONAL | FREQUENT | CONSTANT | SECONDS | MINUTES | HOURS | DAYS | WEEKS |
| N/A | Front of your head (Frontal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| N/A | Entire head (Generalized) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| N/A | Top of your head (Parietal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| N/A | Back of your head (Occipital) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| N/A | In your temples (Temporal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

### Jaw Pain

N/A Jaw pain- upon opening _____

N/A Jaw pain- while chewing _____

N/A Jaw pain- at rest _____

### Jaw Symptoms

- ☐ Jaw clicks _____
- ☐ Jaw locks closed _____
- ☐ Jaw locks open _____
- ☐ Jaw popping _____
- ☐ Teeth clenching _____
- ☐ Teeth grinding _____

## MEDICAL HISTORY (continued)

### Eye-Related Conditions

N/A Blurred vision
N/A Double vision
N/A Eye pain
N/A Pain/Pressure behind eyes
N/A Photophobia (light sensitivity)

### Ear Related Conditions

☐ Buzzing in the ears
☐ Ear congestion
☐ Ear pain
☐ Hearing loss
☐ Pain behind ear
☐ Pain in front of ear
☐ Recurent ear infections
☐ Tinnitus (ringing in the ear)

### Throat, Neck & Back Related Conditions

☐ Back pain- upper
☐ Back pain- middle
☐ Back pain- lower
☐ Chronic sore throat
☐ Constant feeling of a foreign object in throat
☐ Difficulty swallowing
☐ Limited neck movement
☐ Neck pain
☐ Hand/finger numbness
☐ Other _____

☐ Sciatica
☐ Scoliosis
☐ Shoulder pain
☐ Shoulder stiffness
☐ Swelling in the neck
☐ Swollen glands
☐ Thyroid enlargement
☐ Tightness in throat
☐ Tingling hands/fingers
☐ Wryneck

### Mouth & Nose Related Conditions

☐ Broken teeth
☐ Burning tongue
☐ Chronic sinusitis
☐ Dry mouth
☐ Frequent biting of cheek
☐ Frequent snoring

### Lifestyle Related Conditions

☐ Currently under unusual stress
☐ Recent change in lifestyle
☐ Recent change in work pattern

| | |
|---|---|
| Do you drink 2 or more alcoholic beverages per day? Yes ☐ No ☐ | Substance Dependency? Yes ☐ No ☐ _____ |
| Do you drink 4 or more cups of coffee per day? Yes ☐ No ☐ | Do you smoke tobacco? Yes ☐ No ☐ _____ |
| Does any family member have the same or similar problem? Yes ☐ No ☐ | |

If yes, please explain _____

What makes your discomfort/pain worse? _____

## HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe is the cause of your pain or condition? _____

☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Accident ☐ Heredity ☐ Illness ☐ Injury
☐ Unknown ☐ If accident, date _____
☐ Other _____

What other information is important to your pain or condition?

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