TMJ Patient History Form

1. Name _____ Date of Birth _____

   Address _____

   City, State, Zip _____

   Referred by _____

2. In your own words, explain why you are here _____

   _____

   _____

3. Are you presently under the care of a physician or have you been in the past year? Yes ☐ No ☐

   Physician's name _____

   Condition treated _____

   Treatment _____

   Name any medication you are taking _____

4. Dentist's name _____

   Date of last dental appointment _____

   Treatment prescribed _____

5. Do you have any problems with your jaw? Yes ☐ No ☐

   If yes, please describe _____

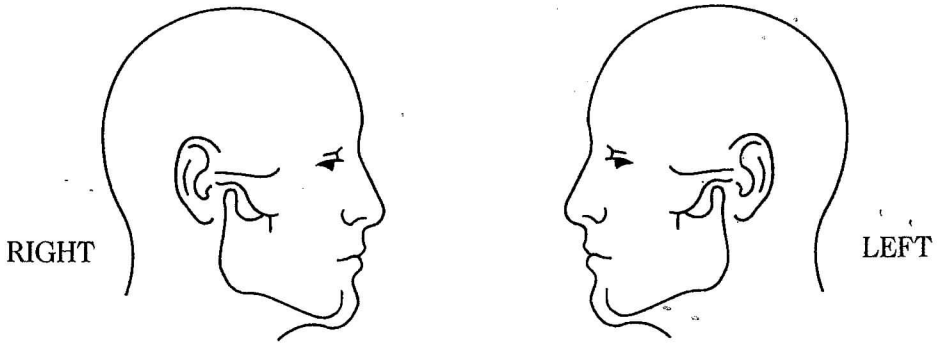
   How long have you had these problems? _____

6. Have you received treatment for jaw problems? Yes ☐ No ☐

   Who directed this treatment? _____

What was the treatment? *(please indicate below)*	Yes	No	Results: Good	Fair	Poor
Bite splint	☐	☐	☐	☐	☐
Medication	☐	☐	☐	☐	☐
Physical therapy	☐	☐	☐	☐	☐
Occlusal adjustment	☐	☐	☐	☐	☐
Orthodontics	☐	☐	☐	☐	☐
Counseling	☐	☐	☐	☐	☐
Surgery	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

7. On the figures below: Mark an X where you have pain
Circle the X where pain is most severe



When do you have this pain? _____

8. Do you do anything now to relieve your pain? Yes ☐ No ☐

If yes, what? _____

9. Are you aware of anything that makes your pain worse? Yes ☐ No ☐

If yes, what? _____

10. Do your jaw joints make noises? Yes ☐ No ☐

RIGHT Clicking ☐ Popping ☐ Grinding ☐ Other _____

LEFT Clicking ☐ Popping ☐ Grinding ☐ Other _____

11. Has your jaw ever locked open? Yes ☐ No ☐

When did this first occur? _____

How often has this occurred? _____

12. Has your jaw ever locked closed or partly closed? Yes ☐ No ☐

When did this first occur? _____

How often has this occurred? _____

13. Have you ever injured your jaws? Yes ☐ No ☐

When? _____

Please describe the injury _____

14. Do you consider yourself to be under more stress than most people? Yes ☐ No ☐

15. Please provide any additional information you feel may be helpful in the diagnosis or treatment of your condition.

_____

_____

_____