History of TMJ Pain and Dysfunction

Please fill out this form to the best of your ability. If there are any questions you do not understand or feel comfortable answering, leave them blank. This form will enable Dr. Levy to make the best diagnosis and long term treatment plan to aid you in your TMD pain management.

Name: _____ Age: _____ Gender: **M** **F** **X**

Occupation: _____ Referral (If Applicable): _____

General Dentist: _____ Primary Care Physician: _____

1. Which of the following statements best describes your issues? (Please choose only one statement)

   ☐ This issue **affects me on a day to day basis** but only causes **mild discomfort** and is manageable without additional treatment.

   ☐ This issue **does interfere** with my day to day activities but the pain is manageable

   ☐ This issue **does interfere** with my day to day activities but the pain is sometimes unmanageable

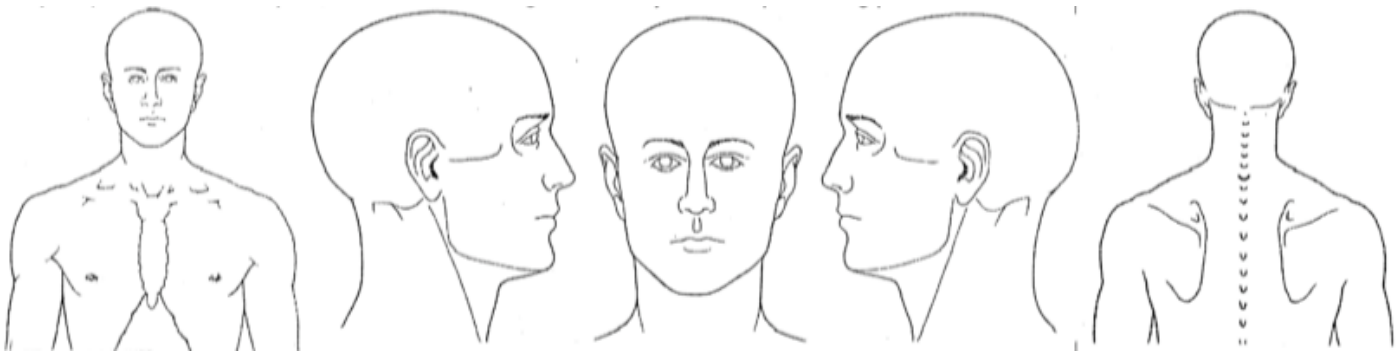
   ☐ This issue **does interfere** with my day to day activities but the pain is often unmanageable

   ☐ This issue **limits** my day to day activities due to **pain** and **limitations of jaw use.**

   ☐ This issue **moderately limits** my day to day activities due to **frequent pain** and **limitations of jaw use.**

   ☐ This issue **severely limits** my day to day activities due to **constant pain** and **limitations of jaw use.**

2. Please indicate on this diagram where you are experiencing pain as well as rating the pain 1-10.



3. Please check all options that relate to the pain you feel, rate each checked option 1-10 based on severity of pain, as well as marking each with an **I** for intermittent or **C** for constant.

☐ Tooth Pain	☐ Jaw Pain	☐ Shoulder Pain
☐ Headaches	☐ Arm Pain	☐ Facial Pain
☐ Ear Pain	☐ Neck Pain	☐ Other _____

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4. Please note the earliest time you can recall feeling is pain. (A close estimate is okay, however try to be as precise as possible.)

   Date of onset was: _____

5. Was the onset of your pain related to an **on the job injury**, **motor vehicle accident**, or other **notable physical trauma**?

   YES_____ **NO**_____

6. If **YES** please briefly describe the nature of the incident or trauma. _____
   _____
   _____

7. If **YES** please note if any symptoms from **#3** were present prior to this injury:

☐ Tooth Pain	☐ Jaw Pain	☐ Shoulder Pain
☐ Headaches	☐ Arm Pain	☐ Facial Pain
☐ Ear Pain	☐ Neck Pain	☐ Other _____

8. Please note **ALL** injuries, accidents, or physical traumas to the head, neck, face, or jaw at **any** time in your life ***prior to*** the onset of pain and ***prior to*** any injury earlier stated. List with dates and brief description of incidents. _____
   _____
   _____
   _____

9. Please check all feelings that are true about your pain and list where on the body you feel each sensation

☐ Stabbing _____	☐ Stabbing _____
☐ Dull _____	☐ Tingling _____
☐ Aching _____	☐ Numbness _____
☐ Throbbing _____	☐ Short Bursts _____
☐ Burning _____	☐ Electric _____

10. The pain is worse or occurs more frequently:

☐ In the morning	☐ During sleep hours
☐ Midday	☐ The pain is constant
☐ In the evening	☐ Other (please describe) _____

11. Does your pain prevent you from necessary daily duties, such as work or school? **YES**_____ **NO**_____

12. Does your pain keep you from falling asleep or awaken you from sleep? **YES**_____ **NO**_____

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13. Do any of the following actions bring on your pain or exacerbate existing pain? (Check all that apply)

☐ Head movement	☐ Eating	☐ Swallowing
☐ Facial expression	☐ Talking	☐ Clenching
☐ Jaw movement	☐ Bathing	☐ Being upset
☐ Tongue movement	☐ Exercise	☐ Being tired

Please list any additional actions that bring on or exacerbate your pain: _____
_____
_____

14. Please list the leisure activities you have been involved with in the past year, and check the most appropriate categories on how your pain affects these activities.

Activities	Now avoid due to pain	Continue to participate despite pain	Able to do without pain
A) _____			
B) _____			
C) _____			

15. Please check the appropriate response in the columns for each of the following activities listed.

	Relieves Pain	Makes Pain Worse	Doesn't Change Pain
Lying down (resting)			
Sitting			
Standing			
Walking			
Light exercise			
Heavy exercise or other physical exertion			
Sleeping			
Drugs; prescription or OTC (please list)			
Alcohol			
Smoking (tobacco or marijuana)			
Massage			
Heat			
Eating			
Talking			
Stress			

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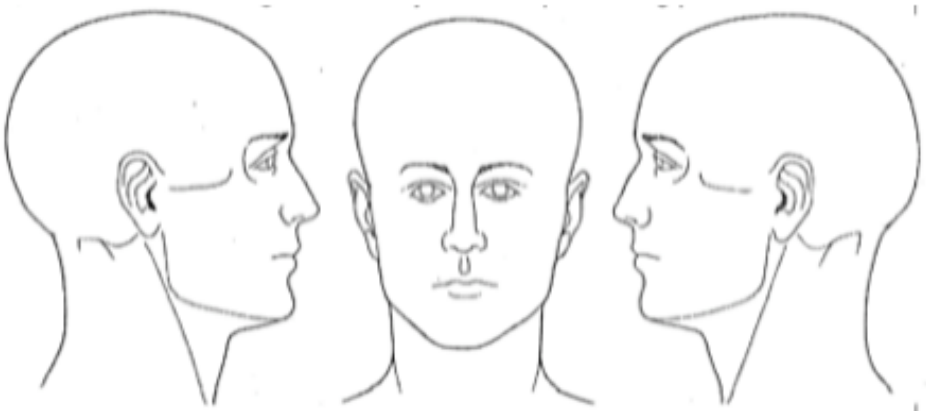
Headache

*(If you do not experience headaches please leave this portion blank and skip to **#25)***

16. Indicate where your headaches typically occur by writing the letters in the key and a number 1-10 on the diagram.

T- Throbbing
A- Aching
S- Stabbing
D- Dull
B- Burning



If you would like, leave
additional brief comments describing your headaches: _____
_____
_____

17. Indicate the frequency of your headaches by selecting one or more of the following:

- ☐ Headache always present
- ☐ Daily, but brief (minutes to an hour)
- ☐ Several headaches per day
- ☐ Daily, but persistent
- ☐ 3-5 per week
- ☐ 1-3 per week
- ☐ 3-5 per month
- ☐ 1-3 per month
- ☐ Other (Explain) _____
  _____

18. Has there been a significant change in the frequency or severity of your headaches recently?

YES_____ **NO**_____ If yes please explain: _____
_____

19. Do any of the following symptoms seem to accompany your headaches or warn you that a headache could be coming?

- ☐ Halo around lights
- ☐ Blind spots
- ☐ Tunnel vision
- ☐ Twinkling lights (floaters)
- ☐ Sensitivity to light
- ☐ Sensitivity to noise
- ☐ Pain or tension when swallowing
- ☐ Upset stomach
- ☐ Light-headedness
- ☐ Tension in body
- ☐ Nausea/vomiting
- ☐ Ear ringing or buzzing
- ☐ Dizziness/vertigo
- ☐ Temporary hearing loss

20. Do any blood relatives have severe reoccurring headaches? If yes, list. **YES**_____ **NO**_____
_____

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21. Does your menstural cycle affect your headaches? (If yes, please explain) **YES**_____ **NO**_____
_____

22. If you are, or have been pregnant, has pregnancy affected your headaches? (If yes, please explain)
YES_____ **NO**_____ (If yes, please explain) _____
_____

23. Has taking birth control ever affected your headaches? **YES**_____ **NO**_____ (If yes, please explain and list which forms of birth control had effects) _____
_____

24. Do your daily activities require prolonged or frequent: (Check all that apply)

- ☐ Maintenance of a specific position (explain) _____
- ☐ Working with your arms in a forward position
- ☐ Working at a desk in a seated position
- ☐ Tilting of your head in a specific direction (explain) _____
- ☐ Turning your head or body into a specific direction (explain) _____
- ☐ Leaning/bending forward
- ☐ Lifting or moving heavy objects
- ☐ Riding in a car
- ☐ Intense concentration
- ☐ Prolonged screen time (estimate screen time per day) _____
- ☐ Riding/driving in a car

25. Do you exercise regularly? **YES**_____ **NO**_____ (list forms of exercise as well as frequency and time intervals) _____
_____

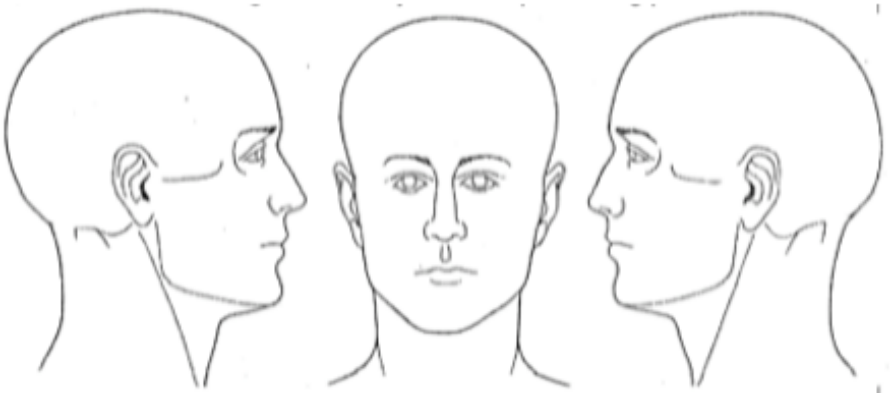
26. Do you more often breath through your nose or your mouth?
_____

Jaw & Facial Pain

*(If you do not experience jaw or facial pain please leave this portion blank and skip to **#29**)*

27. Indicate where your jaw or facial pain occurs by using the letters in the key as well as a number 1-10 on the diagram.

T- Throbbing
A- Aching
S- Stabbing
D- Dull
B- Burning



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28. Do any of the following seem to bring on your jaw or facial pain or exacerbate existing jaw or facial pain?

☐ Head movement
☐ Facial expression
☐ Jaw movement
☐ Tongue movement
☐ Eating
☐ Talking
☐ Bathing
☐ Exercise
☐ Swallowing
☐ Clenching
☐ Being upset
☐ Being tired

List any additional actions that may exacerbate or bring on jaw/facial pain:
_____
_____
_____

29. Have you had your wisdom teeth removed? **YES**_____ **NO**_____
Estimated date of extraction: _____

30. Have you ever had oral, jaw or maxillofacial surgery? **YES**_____ **NO**_____
If yes, please describe, list date of surgery or surgeries, and the doctor(s) or clinics that preformed the procedure(s) _____
_____
_____

31. Have you ever had any cosmetic facial surgeries (plastic surgery)? **YES**_____ **NO**_____
If yes, please describe, list date of surgery or surgeries, and the doctor(s) or clinics that preformed the procedure(s) _____
_____

32. Have you had orthodontic treatment (braces)? **YES**_____ **NO**_____
If yes, list start and end date of treatment, and the doctor(s) or clinic(s) that preformed the orthodontia) _____
_____

33. Do you experience any of the following symptoms? (Check all that apply)

☐ Ringing or buzzing in the ears
☐ Ear fullness or pressure
☐ Temporary hearing loss
☐ Sensitivity to sound
☐ Pain or tightness on swallowing
☐ Dizziness or loss of equilibrium (vertigo)
☐ Light headedness
☐ Sensitivity to light

34. If you have ringing or buzzing in the ears, when did you first notice it? **Date:** _____
Which side does it occur on? **Right**_____ **Left**_____ **Both**_____
Does it seem to be getting worse? **YES**_____ **NO**_____

35. If dizziness or loss of equilibrium (vertigo) is a symptom, when did you first notice it?
Date: _____
Does a change in altitude make this symptom worse? **YES**_____ **NO**_____
Do you feel this when you stand up, or turn too quickly? **YES**_____ **NO**_____

36. Do you have difficulty or pain opening your mouth? **YES**_____ **NO**_____
If yes, please describe: _____
_____

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37. Do either of your jaw joints make noises? **YES**_____ **NO**_____

If yes, mark each sound with the correlating joint.

Left Joint	**Right Joint**
☐Click (short, small noise)	☐Click (short, small noise)
☐Pop (loud, sudden noise)	☐Pop (loud, sudden noise)
☐Grating	☐Grating
☐Grinding	☐Grinding

38. When did these sounds begin? _____

39. If your jaw joints **do not currently** make any of the sounds listed above, have they ever? **YES**_____ **NO**_____ (If yes, note when sounds began and ended as well as the correlating side.) _____

_____

40. Is there pain associated with any of these sounds? **YES**_____ **NO**_____

If yes, note which noises elicit a pain response: _____

_____

41. Does your jaw catch, lock or slip? **YES**_____ **NO**_____

☐Catches (brief difficulty opening) **R**_____ **L**_____
☐Locks Open (cannot close after wide opening) **R**_____ **L**_____
☐Locks closed (cannot open all the way) **R**_____ **L**_____
☐Slips out of place **R**_____ **L**_____

42. Was the onset of your jaw pain gradual or did it suddenly occur at a specific time?

Gradual_____ **Sudden**_____ If ***sudden***, please note the approximate date, if ***gradual*** please briefly describe how long the onset has been: _____

_____

43. Are your jaw muscles tired or sore upon waking? **YES**_____ **NO**_____

44. Do any of the following activities tire your jaw muscles? (check all that apply)

☐Chewing soft foods
☐Chewing hard foods
☐Talking
☐Yawning
☐Dental visits
☐Other _____

45. Which side(s) of your mouth do you typically chew food?

Right_____ **Left**_____ **Both**_____

46. Do you clench your teeth? **YES**_____ **NO**_____

If yes, note when clenching takes place: _____

47. Do you grind your teeth? **YES**_____ **NO**_____

If yes, note when grinding takes place: _____

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48. When you close your mouth to where your teeth fit together best, is your **bite** comfortable?
YES_____ **NO**_____ If no, briefly explain your discomfort: _____
_____

49. When you close your mouth to where your teeth fit together best, is your **jaw** comfortable?
YES_____ **NO**_____ If no, briefly explain your discomfort: _____
_____

50. In the past year, have you been made aware of a change in your bite?
YES_____ **NO**_____ If yes, explain the change(s): _____
_____

51. Do you have ***difficulty eating or have you changed your diet*** due to pain in your face, teeth or jaw joints, difficulty opening, uncomfortable bite, or missing teeth?
YES_____ **NO**_____ If yes, explain the change(s): _____
_____

Previous Treatment for Jaw Pain

52. Have you ever had a bite adjustment? **YES**_____ **NO**_____
Dentist's Name(s) _____
Was this treatment helpful for your jaw pain? _____

53. Have you ever worn a "bite plate", "mouth/night guard", "splint" or other dental appliance **in attempt to help your jaw pain?** **YES**_____ **NO**_____
If yes, who was the dentist that provided the appliance and how were you directed to wear it: _____

54. Have you had any other treatments or therapies for the problem that brings you to this office such as: (Check all that apply)

- ☐ I have had no other treatments
- ☐ Wearing an appliance
- ☐ Bite adjustment
- ☐ Oral/maxillofacial surgery
- ☐ Psychotherapy (counseling)
- ☐ Massage
- ☐ Physical therapy
- ☐ Hypnotherapy
- ☐ Chiropractic adjustment
- ☐ Acupuncture
- ☐ Craniosacral therapy
- ☐ Biofeedback therapy
- ☐ Seen an ENT
- ☐ Other _____

55. Were previous treatments or therapies for this problem beneficial? **YES**_____ **NO**_____
If yes, note which treatments or therapies were beneficial: _____
_____

56. Please list any other dentists or doctors you have seen for the issue which has brought you to this office:

Professional's full name and degree (D.D.S, M.D., etc.)	Location of practice (city)	What treatment or therapy was provided?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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57. Have you ever had a cone beam CT scan for this problem? **YES**_____ **NO**_____
    If yes, where and when was the imaging taken: _____
    _____
58. Did this imaging produce any significant findings? **YES**_____ **NO**_____
    If yes, describe: _____
    _____
59. Have you previously worn a cervical collar, neck brace or had cervical traction for a neck injury?
    YES_____ **NO**_____ If yes, explain why: _____
    _____

Daily Living Profile

The following portion of this form looks into your day to day routines as well as personal history. We understand certain subjects may be sensitive, however It is important that it is filled out honestly and accurately to ensure Dr. Levy is able best diagnose your issue.

60. On average how many eating episodes do you have per day? _____
61. On average how often do you consume caffeinated beverages? _____ times per _____
    What type(s) of caffeinated beverages do you consume? _____
62. On average, how often do you consume alcoholic beverages? _____ times per _____
63. On average, how often do you consume tobacco products? _____ times per _____
64. On average, how often do you consume marijuana products? _____ times per _____
65. Please list any other supplements, substances, or drugs you use on a regular basis as well as frequency of use _____
    _____
66. On average, how long does it take you to fall asleep at night? _____ minutes
67. On average, how how many total hours do you sleep per night? _____ hours
68. Do you have a history of snoring? **YES**_____ **NO**_____
69. Has anyone ever noticed that you stopped breathing during sleep? **YES**_____ **NO**_____
70. Have you ever been told you have “loose joints”, “hypermobile joints” or that you are “double jointed”? (greater joint movement than average) **YES**_____ **NO**_____
71. Are you currently experiencing any joint discomfort other than your jaws and/or neck?
    YES_____ **NO**_____ If yes, explain: _____
    _____
72. Do you feel that you are currently under more emotional stress, or pressure than you would like to be?
    YES_____ **NO**_____ If yes, explain: _____
    _____
73. Do you feel that your emotional stress could be effecting on your pain? **YES**_____ **NO**_____
74. Do you feel that counseling or therapy could help with this? **YES**_____ **NO**_____

Thank you for taking the time to fill out this form, it will greatly aid in your diagnosis and treatment moving forward.

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