TMJ SYMPTOM SCREENING FORM

Patient's Name:_____Date:_____

Chief Concern:_____

Please circle any of the following symptoms you may have:

HEAD/FACE
1. Forehead
2. Temporal
3. Tension headaches
4. Migraine headaches
5. Sinus problems
6. Back of head headaches
7. Hair scalp tender to touch

EAR
1. Ear pain without infection
2. Decreased hearing
3. Clogged, itchy or stuffy
4. Ringing, buzzing
5. Dizziness
6. Balance problems

TRAUMA OR ACCIDENTS
1. Whiplash neck injuries
2. Severe blow to the head or jaw
3. Any serious accidents, such as car accidents

JAW
1. Jaw pain
2. Jaw joint pain
3. Clicking/popping jaw joint
4. Grating sound in jaw joint
5. Pain in cheek muscles
6. Uncontrollable jaw movements
7. Jaw locks open/shut
8. Deviate to one side on opening or closing

BREATHING
1. Snore at night
2. Sleep Apnea

NASAL
1. Sinus pain
2. Sinus problems
3. Post nasal drainage
4. Allergies

EYES
1. Pain in/around eyes
2. Bloodshot eyes
3. Sensitive to light
4. Tearing of eyes
5. Blurred vision
6. Pressure behind eye

NECK
1. Lack of mobility
2. Stiffness
3. Neck pain
4. Tired/sore neck muscles
5. Shoulder pain
6. Back pain: middle, lower

MOUTH
1. Abnormal opening
2. Limited opening
3. Bad bite
4. Missing teeth
5. Excessive mouth breathing
6. Clench or grind teeth
7. Inability to find “bite”
8. Mouth discomfort