Jaw Joint Questionnaire

Patient Name: ___________________________ Date:_________

Form filled out by: _______________________, relationship to patient is: ____________________.

1. Have you ever had clicking, locking, catching, difficulty opening your mouth, or any type of discomfort in the area of the jaw joints? Circle one:
   Yes. If so, please complete this questionnaire
   No. If not, you may stop, you do not need to answer the questions below.
2. Please describe the problems that you are having or have ever had with your jaw joints:
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   When did this symptom(s) start? ____
   What makes this symptom worse (chewing hard foods, yawning, etc)?
   ____
   ____
3. If you have pain, what is the location and the intensity (1-10, with 10 representing severe pain, and 1 representing almost no pain)?
   ____
   ____
4. Does your bite feel uncomfortable or unusual? ____________________________
5. Do you have frequent headaches, and if so, how often?
   ____
6. Describe any injury to your head or neck ________________________
7. Describe any arthritis ____
8. Have you ever had any treatment to help your jaw symptoms?________________
   If yes, please describe treatment and outcome.
   ____