



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.
