

**Nebraska Institute of Cosmetic Dentistry  
TMJ Problem Questionnaire**

PLEASE ANSWER ALL QUESTIONS

DO NOT WRITE IN THIS SPACE

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Referred By \_\_\_\_\_

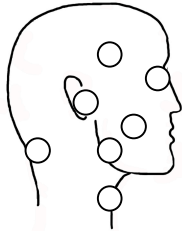
Which of the following do you have? (Check all that apply)

- Headaches     Neck Pain     Jaw Pain     Ear Pain  
 Facial Pain     Other \_\_\_\_\_

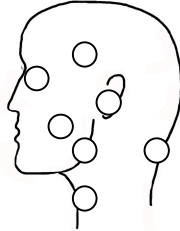
Which Side Hurts?     Both     Right     Left

Comments \_\_\_\_\_

Darken the circle(s) where you hurt.



Right Side



Left Side

How long have you had this pain? \_\_\_\_\_

Is the pain constant? \_\_\_\_\_

Is the pain:     Aching     Burning     Stabbing

Other \_\_\_\_\_

Is the pain the worst in the: check all that apply

Morning     Afternoon     Evening     Night

Have you ever injured or sustained any form of trauma or whiplash to your:     Jaw     Head     Neck

If so, please complete the trauma questionnaire.

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

What medication(s) do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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Have you had any prior treatment for TMJ?	Yes	No	
-Splint?	Yes	No	When? _____
			Did it help?    Yes    No
- Nightguard?	Yes	No	When? _____
			Did it help?    Yes    No
- Bite Adjustment?	Yes	No	When? _____
			Did it help?    Yes    No
-Orthodontics?	Yes	No	When? _____
			Did it help?    Yes    No
Other? _____			

Describe the problems in your own words as you understand them.

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Reports may be sent to my:

- Medical Doctor \_\_\_\_\_
- Dentist \_\_\_\_\_
- Other \_\_\_\_\_

I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing. I consent to the use of my x-rays, records, and photos for scientific publication or teaching providing my name be anonymous.

X \_\_\_\_\_  
Signature

Date \_\_\_\_\_