TMJ INITIAL EXAM FORM

WHAT IS THE MAIN REASON YOU ARE HERE?

__Bruxism__  __Grating Jaw Noises__  __Muscle Pain__  __Spontaneous TMJ Pain__  
__Burning Mouth__  __Headaches__  __Neck Pain__  __Teeth don’t fit__  
__Clenching__  __Heavy Snoring__  __Numbness__  __Temple Pain__  
__Dizziness__  __Jaw Locked Closed__  __Oral Ulcers/Sores__  __TMJ Pain on Closing__  
__Earaches__  __Jaw Locks Open__  __Painful Jaw Clicking__  __TMJ Pain on Opening__  
__Eye Pain__  __Jaw Pain__  __Painless Jaw Clicking__  __TMJ Pain with Chewing__  
__Facial Pain__  __Jaw won’t open wide__  __Ringing in Ears__  __Tongue Pain__  
__Forehead Pain__  __Lip Pain__  __Sinus Pain__  __Tooth Pain__  

Other________________________________________________________________________________

PLEASE PLAN AN “X” ON THE PRIMARY LOCATION OF YOUR PAIN

[Diagram showing pain locations]

DESCRIBE YOUR PAIN

__Aching__  __Deep__  __Localized__  __Sudden Onset__  
__Annoying__  __Diffuse__  __Pressure__  __Superficial__  
__Bilateral__  __Dull__  __Radiating__  __Tightness__  
__ Burning__  __Electric-like__  __Sharp__  __Throbbing__  
__Crushing__  __Gradual Onset__  __Steady__

[Diagram showing pain locations]
**WHAT BROUGHT ON THESE COMPLAINTS?**

- Following a Dental Procedure  
- Following a Motor Vehicle Accident ___-___ (Date)  
- Following a Surgical Procedure  
- Following Trauma to the Head  
- Following Trauma to the Neck

Other ________________________________

**HOW LONG HAVE YOU HAD THESE COMPLAINTS?**

- As long as I can remember  
- Days  
- Months  
- Years  
Since the age of____

Other ________________________________

**DESCRIBE THE FREQUENCY OF YOUR PAIN**

- Constant  
- Weekly  
- Daily  
- Intermittent  
- Monthly

**DURATION OF EPISODES**

- Seconds  
- Minutes  
- Hours  
- Days

**WHEN IS YOUR CHIEF COMPLAINT WORST?**

- At Any Time of the Day  
- In the Morning  
- When Under Stress  
- In the Evening  
- After Eating  
- Midday  
- While Eating  
- Variably  
- During Menstrual Cycle  
- Upon Awakening  
- Variably

Other ________________________________

**WHAT OTHER PRACTITIONERS HAVE YOU SEEN FOR YOUR CHIEF COMPLAINT?**

- No Other Practitioners  
- Acupuncturist  
- Allergist  
- Anesthesiologist  
- Chiropractor  
- Dermatologist  
- Endocrinologist  
- Endodontist  
- Internist  
- Neurologist  
- Orthodontist  
- Physical Therapist  
- Psychiatrist  
- Psychologist  
- Rheumatologist  
- Surgeon

Other ________________________________
WHAT WAS THE SUCCESS OF THIS TREATMENT

__Complete  __Significant  
__Minimal  __None  

HEALTH HISTORY

MARK ALL RESPONSES YOU HAVE HAD OR CURRENTLY HAVE:

__No Related Medical Problems  
__Aids  __Emphysema  __Leukemia  __Radiation Treatment  
__ARC  __Fracture(s)  __Liver Disease  __Reproductive Tract Disorder  
__Anemia  __Fainting/Dizziness  __Mononucleosis  __Seizures  
__Anxiety  __Heart Disease  __Nervous Breakdown  __Stomach Ulcers  
__Arthritis  __Heart Murmur  __Neuralgia  __Urinary Tract Problems  
__Asthma  __Hemophilia  __Neurosis  __Weight Gain/Loss  
__Bronchitis  __Hepatitis  __Parkinson’s Disease  __Yeast (Fungus)  
__Cancer  __History of Prior Surgery  __Pregnancy  
__Chemotherapy  __Hormonal Disturbance  __Psychiatric Counseling  
__Depression  __Hypertension  __Psychologic Counseling Related to Chief Complaint  
__Dermatitis  __Hypotension  __Psychologic Counseling Not Related to Chief Complaint  
__Diabetes  __Kidney Disease  

Other

PLEASE MARK THE APPROPRIATE RESPONSES

__I Feel Depressed  __I Feel Anxious  
__I Have Thought About Suicide  __I Have Difficulty Sleeping  

Other

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY USING FOR YOUR CHIEF COMPLAINT

____________________________________________________________________________________

____________________________________________________________________________________

PLEASE LIST MEDICATIONS THAT WERE PAST EFFECTIVE FOR YOUR CHIEF COMPLAINT

____________________________________________________________________________________

____________________________________________________________________________________

PLEASE LIST MEDICATIONS THAT WERE PAST INEFFECTIVE FOR YOUR CHIEF COMPLAINT

____________________________________________________________________________________

____________________________________________________________________________________
PLEASE LIST OTHER MEDICATIONS TAKEN

_____________________________________________________________________________________
_____________________________________________________________________________________

DO YOU USE TOBACCO?

___Do Not Smoke
___Smoke a Pipe Times a Day___ How Many Years___
___Smoke Cigarettes Packs a Day___ How Many Years___
___Smoke Cigars Cigars a Day___ How Many Years___
___Smokeless Tobacco _____ Per Day

Other

HOW OFTEN DO YOU CONSUME ALCOHOL?

___1-3 Ounces Daily
___Less than One Ounce Daily

___More than 3 Ounces Daily
___No Alcoholic Beverages

Other

CAFFEINE HISTORY

___Cups of Caffeinated Coffee Daily
___Ounces of Caffeinated Soda Daily

___No Caffeinated Beverages

ALLERGIES

___NO KNOWN ALLERGIES

___Codeine
___General Anesthesia
___Penicillin
___Bug Bites
___Hay Fever
___Sulfa Drugs
___Dust and Pollen
___Medication Allergies

___Food Allergies

Other

DESCRIBE PREVIOUS DENTAL TREATMENTS

___Bite Adjustment
___Bite Splint
___Crowns or Bridges
___Fractured Jaw

___Gum Surgery
___Oral (Not TMJ) Surgery
___Orthodontics
___Teeth Extracted and Not Replaced

___Removable Dentures
___Root Canals
___Routine Dental Care
___TMJ Surgery

___Widsom Teeth Extracted

Other
WHAT MAKES YOUR PAIN WORSE?

__Alcohol__
__Driving__
__Opening Wide__
__Stress__
__Bending Over__
__Exertion__
__Pressure__
__Talking__
__Cold__
__Hot__
__Singing__
__Chewing__
__Lying Down__
__Sitting__

Other __________________________________________________________________________________

WHAT REDUCES YOUR PAIN?

__Hot Compresses__
__Massage__
__Rest__
__Cold Compresses__
__Medication__
__Sleep__

Other __________________________________________________________________________________

Example: If you have pain that is on average midway between “No Pain” at all and the “Most Pain” you have ever experienced, then you should place a mark midway on the line.

No Pain..........................................................................................................................Most Pain

PLEASE PLACE A MARK ON EACH OF THE LINES BELOW SHOWING YOUR PAIN LEVEL

PAIN NOW

NO PAIN.........................................................................................................................MOST INTENSE PAIN

PAIN IN PAST

NO PAIN.........................................................................................................................MOST INTENSE PAIN

PAIN WITH CHEWING

NO PAIN.........................................................................................................................MOST INTENSE PAIN

PLEASE MARK THE APPROPRIATE RESPONSES RELATED TO ANY SLEEP PROBLEMS

__No Sleep Problems__
__Difficulty Returning to Sleep__
__Fatigued on Awakening__
__Awakened by Pain__
__Teeth Grinding/Clenching__
__Frequent Awakenings__
__Daytime Sleepiness__
__Not Due to Chief Complaint__
__Difficulty falling asleep Due to Chief Complaint__
__Due to Chief Complaint__
__Difficulty Falling Asleep NOT Due to Chief Complaint__
__None__

Other __________________________________________________________________________________
HAVE YOU HAD PREVIOUS HEADACHES DIAGNOSED?

__Cluster  __Migraine with Aura  __Migraine without Aura
__Tension-Type Headache  __Sinus  __Not been Diagnosed

Other

PLEASE CHECK THE APPROPRIATE RESPONSES RELATED TO ANY EAR PROBLEMS

__Drainage  __No Problems
__Hearing Loss  __Stiffness
__Hypersensitive Hearing  __Ringing in Ears
__Itching  __Dizziness

Other

**PLEASE SKIP THIS NEXT SECTION IF YOU HAVE NOT BEEN INVOLVED IN AN AUTO ACCIDENT**

DESCRIBE YOUR ACCIDENT:

_____________________________________________________________________________________

_____________________________________________________________________________________

DATE OF ACCIDENT:_________________________________

RERAINT

__Restrained by Deployed Airbag Only  __Restrained by Seat Belt Only
__Restrained by Harness and Airbag  __Restrained by Shoulder Harness
__Restrained by Seat Belt and Air Bag  __Unrestrained

YOUR LOCATION DURING THE ACCIDENT

__In the Driver’s Seat  __In the Back Left Seat
__In the Right Front Passengers Seat  __In the Back Right Seat
__In the Center Front  __In the Center Back
__In the Middle Seat

TYPE OF VEHICLE

__Car  __Truck  __Van
PRIMARY IMPACT TO THE VEHICLE

__Front___Right Door Panel
__Front Left___Right Front Quarter
__Front Right___Right Rear Quarter
__Left Door Panel___Rear
__Left Front Quarter___Rear Left
__Left Rear Quarter___Rear Right

IMPACT WAS WITH

__A Stationary Object___A Vehicle Moving from Right to Left
__A Vehicle Moving from Left to Right___A Vehicle Moving Parallel to Yours

APPROXIMATE SPEED AT THE TIME OF IMPACT

__1 MPH___30 MPH
__5 MPH___40 MPH
__10 MPH___50 MPH
__15 MPH___60 MPH
__20 MPH___IN EXCESS OF 60 MPH
__25 MPH

SECONDARY IMPACT

__Did Not Occur___Was to the Rear of the Vehicle
__Was Due to a Vehicle Rollover___Was to the Left of the Vehicle
__Was to the Front of the Vehicle___Was to the Right of the Vehicle

LOCATION OF SUSTAINED TRAUMA

__No Direct Trauma to the Head or Face
__Direct Trauma to the Top of the Head
__Direct Trauma to the Forehead: ___Left ___Right ___Bilateral
__Direct Trauma to the Back of the Head
__Direct Trauma to the Jaw: ___Left ___Right ___Bilateral
__Direct Trauma to the Jaw Point: ___Left ___Right ___Bilateral
__Direct Trauma Behind the Ear: ___Left ___Right ___Bilateral
__Direct Trauma to the Ear: ___Left ___Right ___Bilateral
__Direct Trauma to the Cheek: ___Left ___Right ___Bilateral
__Direct Trauma to the Chin
__Direct Trauma to the Nose
__Direct Trauma to the Lips
__Fracture of a Tooth or Teeth
__Direct Trauma to the Philtrum Region
SYMPTOMS OF THE TMJ/FACIAL PAIN WERE FIRST NOTED

__The Day of the Impact  __One Month Later
__The Next Day  __Six Months Later
__One Week Later  __One Year or More Later

IS THE PATIENT PRESENTLY AT MMI

__Yes  __No  __Unknown

PRESENCE OF PARTIAL PERMANENT IMPAIRMENT

__None
__Joint Dysfunction: __%
__Fracture: __%
__Disc Displacement: __%
__Hypo-Mobility __%
__Surgical Intervention: __%

END OF ACCIDENT SECTION