

Version: TMDQV1

TMJ Screening Consultation

OFFICE USE
Patient ID: _____

NAME: _____

CURRENT DATE: ___/___/___

DATE OF BIRTH: ___/___/___

MALE

FEMALE

Referring Physician: _____

Contact ID: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

Number
#1 = the most severe symptom

- Jaw pain
- Jaw clicking
- Jaw locking
- Limited mouth opening
- Facial pain
- Neck pain
- Headaches

Number
#1 = the most severe symptom

- Migraines
- Morning head pain
- Ringing in the ears
- Dizziness
- Nocturnal teeth grinding
- Frequent Heavy Snoring
- Pain when chewing

Other: Write In

Symptoms

HEAD PAIN

- Entire head (Generalized)
- L R B Face Pain
- L R B Front of your head (Frontal)
- Top of the head
- L R B Back of your head
- L R B In your temples

JAW PAIN

- L R B Jaw pain - on opening
- L R B Jaw pain - while chewing

L R B

Jaw pain - at rest

JAW SYMPTOMS

- Jaw popping
- L R B Jaw clicking
- Jaw locks closed
- L R B Face Pain
- Jaw locks open
- Teeth grinding

MOUTH AND NOSE RELATED CONDITION

- Burning tongue

Patient Signature: _____

Date: _____