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
- [ ] Migraines

Number
#1 = the most severe symptom

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

Other: Write In

Symptoms

HEAD PAIN

L R B Front of your head (Frontal)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks

L R B Entire head (Generalized)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks

L R B Top of your head (Parietal)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks

L R B Back of your head (Occipital)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks

Patient Signature: Date:

Symptoms

HEAD PAIN

In your temples (Temporal)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks

Pain behind the ear

JAW PAIN

Jaw pain - on opening

Jaw pain - while chewing

Jaw pain - at rest

JAW SYMPTOMS

Jaw popping

Jaw clicking

Jaw locks closed

Jaw locks open

Teeth grinding

MOUTH AND NOSE RELATED CONDITION

Burning tongue

Frequent biting of cheek

Frequent snoring

Broken teeth

Teeth clenching

Dry mouth

EAR RELATED CONDITIONS

Buzzing in the ears

Tinnitus (ringing in the ears)

Ear pain

Ear congestion

Pain in front of the ear

Hearing loss

Recurrent ear infections

Other

EYE RELATED CONDITIONS

Blurred vision

Eye pain

Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

Back pain - lower

Back pain - middle

Back pain - upper

Chronic sore throat

Constant feeling of a foreign object in throat

Difficulty in swallowing

Limited movement of neck

Neck pain

Numbness in the hands or fingers

Sciatica

Scoliosis

Shoulder pain

Shoulder stiffness

Swelling in the neck

Swollen glands

Thyroid enlargement

Tightness in throat

Tingling in the hands or fingers

Chronic sinusitis

Patient Signature:

Date:

History Of Symptoms

Is there anything that makes your pain or discomfort worse?

What other information is important regarding the pain or condition?

Is there anything that makes your pain or discomfort better?

Other

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

DATE OF ACCIDENT OR INCIDENT:

Enter date (month/day/year)

THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:

Select one:

- A motor vehicle accident
- A motorcycle accident
- A work related incident
- A playground incident
- An athletic endeavor
- A fight
- A fall
- An accident
- Hit by an object
- Hit an object
- An illness
- An injury
- Orthodontics
- Dental procedures
- Whiplash

Other:

Patient Signature: Date:

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

HISTORY OF ACCIDENT

WERE YOU:

Select one:

A passenger in a motor vehicle

The driver of a vehicle

A pedestrian

At work

Did you fall?

Were you hit by an object?

Did you hit an object?

Other:

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

At the front end

At the rear end

At the front right area

At the front leftt area

At the rear right area

At the rear left area

Head on

On driver's side

On passenger's side

Other area:

INDICATE IF THERE WAS ANY TRAUMA:

The patient's:

Forehead

Face

Chin

Side of head

Back of head

Top of head

Teeth

Jaw

Other:

Forcibly struck the:

Steering wheel

Windshield

Passenger's side window

Driver's side window

Passenger's side door

Driver's side door

Headreast

Seat

Roof

Interior of the car

Other:

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Patient Signature: Date:

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Head Pain History

Pain Qualities

--- LOCATION ---

Jaw Pain on a Numeric Pain Scale

Headaches on a 0-10 Pain Scale

Neck Pain on a Numeric Pain Scale

Facial Pain on a 0-10 Pain Scale

Which side are the headaches worse?

- depends
- both sides
- the left side
- the right side

FREQUENCY

- 6-8 months
- 3-5 per week
- occasional (0-3/mo)
- frequent (3-6/mo)
- constant

Headache spreads to

- the temple. back of head and forehead
- the templ & back of the head
- the temple
- the back of the head
- the temple
- the back of the head
- the forehead

--- DURATION ---

- Seconds
- Minutes
- Hours
- Days
- Weeks

--- SEVERITY ON A SCALE OF 0-10 ---

--- 0=No Pain 10=Worst Pain Imaginable ---

When having pain do you experience:

- Dizziness
- Double vision
- Fatigue
- Nausea
- Sensitivity to light (photophobia)
- Sensitivity to noise
- Throbbing
- Vomiting
- Burning

Other

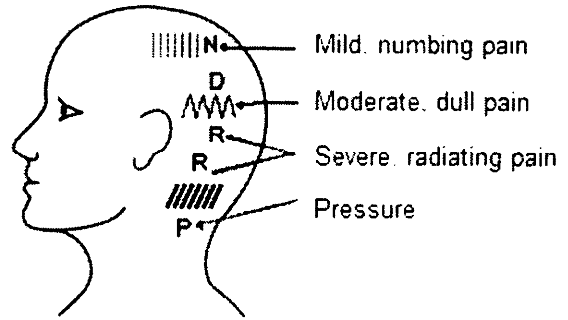
Patient Signature: Date:

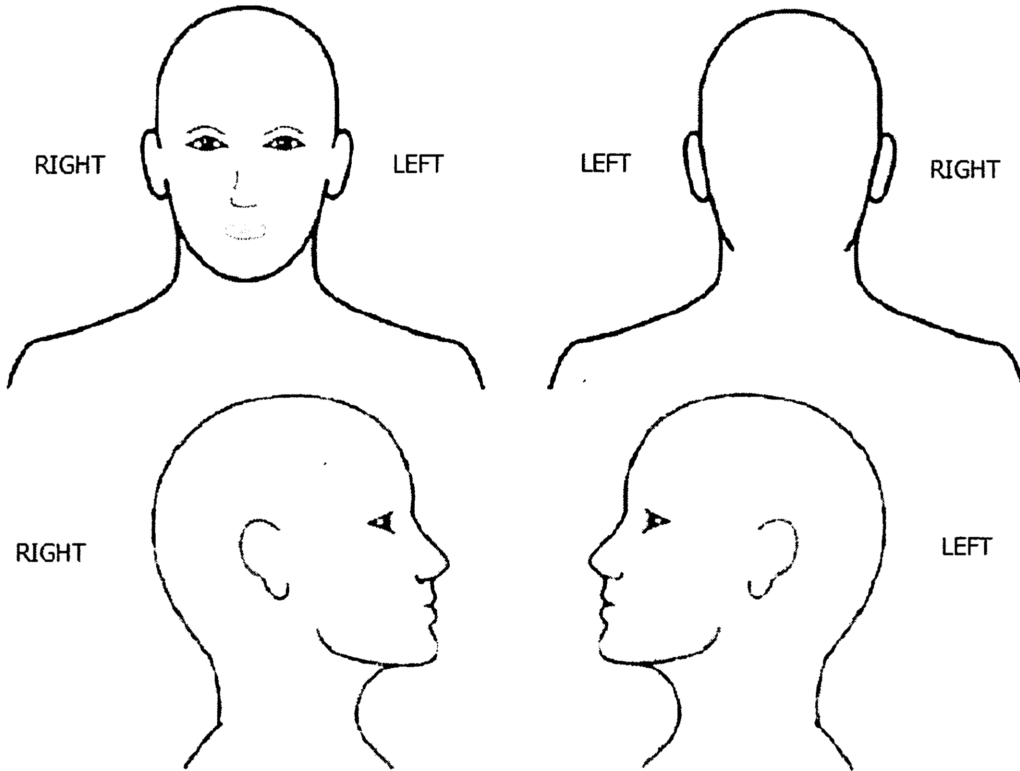
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||
MODERATE PAIN ΛΛΛΛ
SEVERE PAIN ///////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating





Enter any text to appear below the image:

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: Date:

I certify that the medical history information is complete and accurate.

Patient Signature: Date: