GENERAL HISTORY

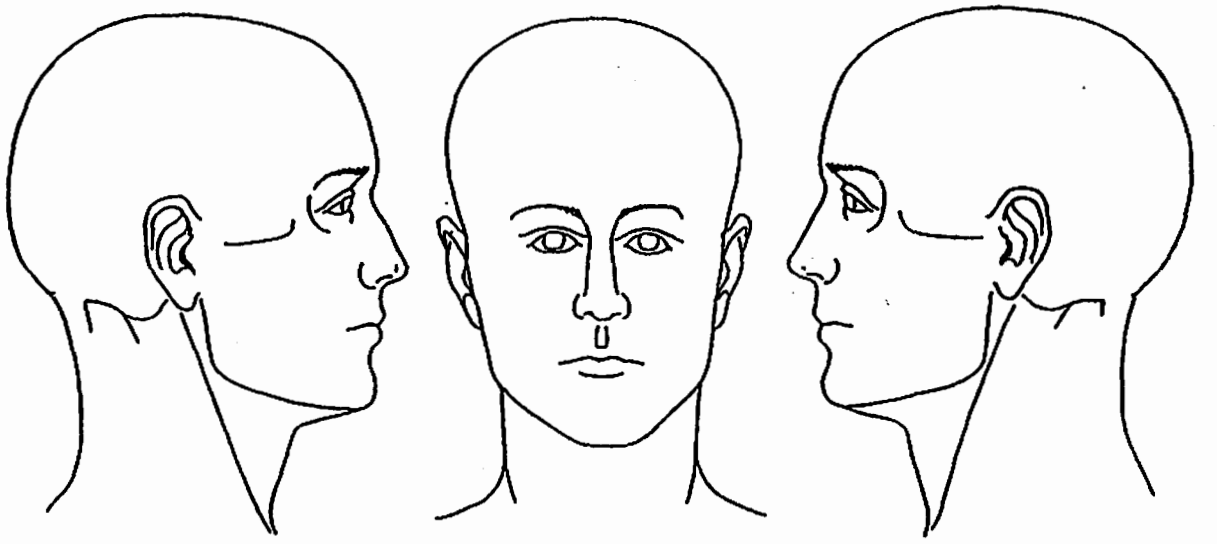
NAME _____ AGE _____ DATE _____

CHIEF COMPLAINT _____

DATE OF INJURY _____ OCCUPATION _____

REFERRING PHYSICIAN _____

FACE DIAGRAM: Please shade in the area of discomfort on the diagram below.



DISCOMFORT SEVERITY SCALE: 0 (no pain) _____ 10 (worst pain)

HISTORY: Please check "yes" or "no"

HEART DISEASE	___	___
RESPIRATORY PROBLEMS	___	___
ALLERGIES	___	___
DIABETES	___	___
CANCER	___	___
OSTEOPOROSIS	___	___
CORTISONE	___	___

SPECIAL TESTS:

X-RAYS	___	___
LABORATORY	___	___
MYELOGRAM	___	___
ARTHROGRAM	___	___
OTHER TEST	___	___

APPROXIMATELY HOW LONG HAVE YOU HAD THIS PROBLEM ? _____.

DOES YOUR JAW JOINT, GRATE _____; CLICK _____; POP _____; SNAP _____; OR LOCK _____.
WHICH SIDE ? RIGHT _____ LEFT _____ BOTH _____.

DO YOU HAVE HEADACHES ? YES ___ NO ___. HOW OFTEN ? DAILY ___; SEVERAL TIMES A WEEK ___.
HAVE YOU EVER BEEN IN AN AUTO ACCIDENT ? YES/NO WHEN: _____.
LIST RELATED SURGERIES & DATES: _____
_____.

HAVE YOU EVER WORN BRACES ON YOUR TEETH ? YES ___ NO ___ WHEN: _____.
HAVE YOU EVER WORN A SPLINT IN YOUR MOUTH ? YES ___ NO ___ WHEN: _____.
WHY: _____.
HAVE YOU HAD ANY SIMILAR PROBLEMS IN THE PAST ? IF SO, PLEASE EXPLAIN: _____
_____.
ARE YOU NOW ON ANY MEDICATION FOR THIS PROBLEM OR ANY OTHER PROBLEM ? _____
_____

PROBLEMS POSSIBLY PERTINENT TO PRESENT CONDITION: (Please Check)

	YES	NO
INJURY	___	___
VIRUS OR FLU JUST PRIOR	___	___
OVER TIRED JUST PRIOR	___	___
IMMOBILIZATION	___	___
UNUSUAL ACTIVITY	___	___

WHAT IS YOUR GENERAL LEVEL OF ACTIVITY ? (Please Circle)

Inactive Mildly Active
Moderately Active Very Active

HAS YOUR LEVEL OF ACTIVITY CHANGED ? _____.
IS YOUR GENERAL LEVEL OF STRESS OR ANXIETY: mild; moderate; severe
HAS YOUR LEVEL OF STRESS CHANGED ? _____.
WHEN DID THE PAIN BEGIN ? (date) _____.
WAS THE PAIN SUDDEN ___, GRADUAL ___, OTHER _____?
IS YOUR PROBLEM GETTING WORSE ___, BETTER ___, OR NOT CHANGING ___ ?
WHEN THE PROBLEM BEGAN, WAS YOUR DISCOMFORT IN EXACTLY THE SAME LOCATION AS YOU HAVE IT NOW ?
_____
IS THE PAIN CONSTANT OR INTERMITTENT ? _____.
DOES YOUR PAIN BEGIN IN THE MORNING: AS THE DAY PROGRESSES; OR AT BEDTIME ? _____.
WHAT AGGRAVATES YOUR PROBLEM ? _____.
WHAT RELIEVES YOUR PROBLEM ? _____.
DOES YOUR DISCOMFORT EVER AWAKE YOU AT NIGHT ? _____.
IS IT HARD FOR YOU TO GET BACK TO SLEEP AFTER YOU ARE AWAKEN ? IF SO, HOW LONG ? _____
_____

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

ANY SIGNIFICANT CHANGES IN WEIGHT LATELY ? _____

ANY CHANGES IN YOUR APPETITE LATELY ? _____

ANY CHANGES IN BOWEL OR BLADDER FUNCTION LATELY ? _____

ANY FEELING OF BEING OVERTIRED LATELY ? _____

ANY SHORTNESS OF BREATH ? _____

ANY GENERAL WEAKNESS, NAUSEA, DIZZINESS OR FEELING FAINT ? _____

SPECIFIC WEAKNESS OR LACK OF COORDINATION OR UNSTEADINESS ? _____

ANY DISCOMFORT ON EXERTION ? _____

ANY UNUSUAL DISCOLORATION OF SKIN ? _____

ANY SENSITIVITY TO COLD ? _____

IS THERE ANYTHING ELSE PERTINENT TO YOUR PROBLEM THAT WE HAVE NOT DISCUSSED ?

_____

_____

_____

PATIENT'S GOALS: (1)

(2)

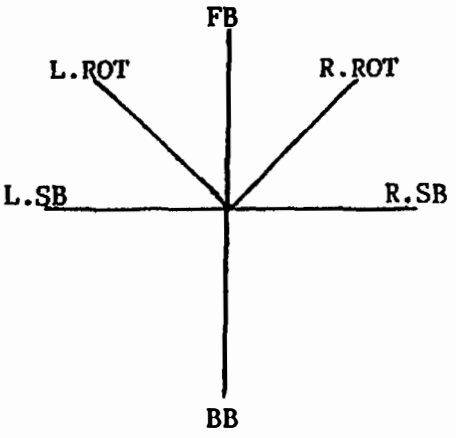
(3)

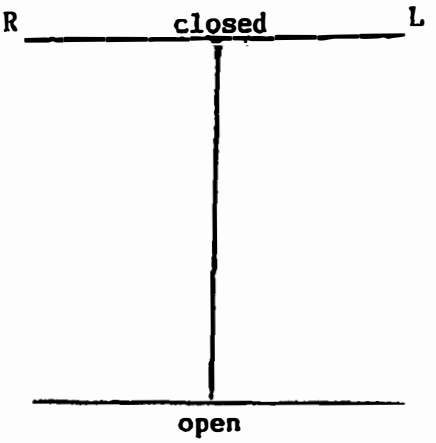
THERAPIST COMMENTS AND NOTES:

OBJECTIVE EVALUATION FORM (THERAPIST USE ONLY)

OBSERVATION & INSPECTION:

POSTURE:





ACTIVE RANGE OF MOTION:

PALPATION:

	LEFT	RIGHT
UPPER TRAPEZIUS		
BODY	____	____
OCCIPUT	____	____
LEVATOR SCAPULAE	____	____
SUBOCCIPITAL	____	____
TEMPORALIS	____	____
MASSETER	____	____
SCM	____	____
TEMPORALIS TENDON	____	____
LATERAL PTERYGOID	____	____

NEUROLOGY:

SENSATION _____

REFLEXES _____

STRENGTH (MMT) _____

PROM: _____

JOINT NOISES: _____

ASSESSMENT: _____

TREATMENT: _____

GOALS: (1)
(2)
(3)
(4)

PLAN: _____

_____

EXERCISES:

Name: _____

Date: _____

JAW FUNCTIONAL LIMITATION SCALE

For each of the items below, please indicate the level of limitation **during the last month.** If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, then leave the item blank.

		No Limitation										Severe Limitation
1	Chew tough food	0	1	2	3	4	5	6	7	8	9	10
2	Chew hard bread	0	1	2	3	4	5	6	7	8	9	10
3	Chew chicken (for example, prepared in oven)	0	1	2	3	4	5	6	7	8	9	10
4	Chew crackers	0	1	2	3	4	5	6	7	8	9	10
5	Chew soft food (for example, macaroni, canned or soft fruits, cooked vegetables, fish)	0	1	2	3	4	5	6	7	8	9	10
6	Eat soft food requiring no chewing (for pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10
7	Open wide enough to bite from a whole apple	0	1	2	3	4	5	6	7	8	9	10
8	Open wide enough to bite into a sandwich	0	1	2	3	4	5	6	7	8	9	10
9	Open wide enough to talk	0	1	2	3	4	5	6	7	8	9	10
10	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10
11	Swallow	0	1	2	3	4	5	6	7	8	9	10
12	Yawn	0	1	2	3	4	5	6	7	8	9	10
13	Talk	0	1	2	3	4	5	6	7	8	9	10
14	Sing	0	1	2	3	4	5	6	7	8	9	10
15	Putting on a happy face	0	1	2	3	4	5	6	7	8	9	10
16	Putting on an angry face	0	1	2	3	4	5	6	7	8	9	10
17	Frown	0	1	2	3	4	5	6	7	8	9	10
18	Kiss	0	1	2	3	4	5	6	7	8	9	10
19	Smile	0	1	2	3	4	5	6	7	8	9	10
20	Laugh	0	1	2	3	4	5	6	7	8	9	10

No Pain At All — Pain As Bad As It Could Be

0 _____ 10

The Oral Behavior Checklist

How often do you do each of the following activities, based on the last month? If the frequency of the activity varies, choose the higher option. Please place a (√) response for each item and do not skip any items.

	Activities During Sleep	None of the time	< 1 Night /Month	1-3 Nights /Month	1-3 Nights /Week	4-7 Nights/ Week
1	Clench or grind teeth **when asleep**, based on any information you may have	☐	☐	☐	☐	☐
2	Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side)	☐	☐	☐	☐	☐
	Activities During Waking Hours	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
3	Grind teeth together **during waking hours**	☐	☐	☐	☐	☐
4	Clench teeth together **during waking hours**	☐	☐	☐	☐	☐
5	Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth)	☐	☐	☐	☐	☐
6	Hold, tighten, or tense muscles without clenching or bringing teeth together	☐	☐	☐	☐	☐
7	Hold or jut jaw forward or to the side	☐	☐	☐	☐	☐
8	Press tongue forcibly against teeth	☐	☐	☐	☐	☐
9	Place tongue between teeth	☐	☐	☐	☐	☐
10	Bite, chew, or play with your tongue, cheeks or lips	☐	☐	☐	☐	☐
11	Hold jaw in rigid or tense position, such as to brace or protect the jaw	☐	☐	☐	☐	☐
12	Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc	☐	☐	☐	☐	☐
13	Use chewing gum	☐	☐	☐	☐	☐
14	Play musical instrument that involves use of mouth or jaw (for example, woodwind, brass, string instruments)	☐	☐	☐	☐	☐
15	Lean with your hand on the jaw, such as cupping or resting the chin in the hand	☐	☐	☐	☐	☐
16	Chew food on one side only	☐	☐	☐	☐	☐
17	Eating between meals (that is, food that requires chewing)	☐	☐	☐	☐	☐
18	Sustained talking (for example, teaching, sales, customer service)	☐	☐	☐	☐	☐
19	Singing	☐	☐	☐	☐	☐
20	Yawning	☐	☐	☐	☐	☐
21	Hold telephone between your head and shoulders	☐	☐	☐	☐	☐

TMD PAIN QUESTIONNAIRE

Patient Name: _____ Date: _____

Please circle the ONE choice that best pertains to you (*not necessarily exactly*) in each of the following categories.

SECTION 1- Communication (talking)

1. I can talk as much as I want, without pain, fatigue, or discomfort.
2. I talk as much as I want, but it causes some pain, fatigue, and/or discomfort.
3. I can't talk as much as I want because of pain , fatigue, and/or discomfort.
4. I can't talk much at all because of pain, fatigue, and/or discomfort.
5. Pain prevents me from talking at all.

SECTION 2-Normal Living Activities (brushing teeth/flossing)

1. I am able to care for my teeth and gums in a normal fashion without restriction, without pain, fatigue, or discomfort.
2. I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort or jaw tiredness results.
3. I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort and jaw tiredness no matter how slow and careful I am.
4. I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
5. I am unable to care for my teeth and gums because of restricted opening an/or pain.

SECTION 3- Normal living activities (eating, chewing)

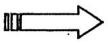
1. I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
2. I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
3. I can't eat much of anything I want because it often causes pain/discomfort, jaw tiredness, or because of restricted opening.
4. I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue, and/or restricted opening.
5. I must stay on a liquid diet because of pain and/or restricted opening.

SECTION 4-Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur, sports/hobbies, and recreation, etc)

1. I am enjoying a normal social life and/or recreational activities without restrictions.
2. I participate in normal social life and/or recreational activities but pain/discomfort is increased.
3. The presence of pain/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instruments, singing).
4. I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
5. I have practically no social life because of pain.

SECTION 5-Non-specialized jaw activities (yawing, mouth opening, and opening mouth wide)

1. I can yawn in a normal fashion, painlessly.
2. I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
3. I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
4. Yawning and opening my mouth wide are somewhat restricted by pain.
5. I cannot yawn or open my mouth more than two fingers widths (2.8-3.2 cm) or, if I can, it always causes greater than moderate pain.



SECTION 6-Sexual function (including kissing, hugging, and any all sexual activities to which you are accustomed)

1. I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face, or jaw pain.
2. I am able to engage in all my customary sexual activities and expressions, but it sometimes causes some headache, face, or jaw pain, or fatigue.
3. I am able to engage in all my customary sexual activities but it usually causes enough headache, face, or jaw pain to markedly interfere with my enjoyment, willingness, and satisfaction.
4. I must limit my customary sexual expressions and activities because of headache, face, or jaw pain, or limited mouth opening.
5. I abstain from almost all sexual activities and expression because of the head, face, or jaw pain it causes.

SECTION 7-Sleep (restful, nocturnal, sleep pattern)

1. I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
2. I sleep well with the use of pain pills, anti-inflammatory medication, or sleeping p ills.
3. I fail to realize 6 hours restful sleep even with the use of pills.
4. I fail to realize 4 hours restful sleep even with the use of pills.
5. I fail to realize 2 hours restful sleep even with the use of pills.

SECTION 8-Effects of any form of treatment, including but not limited to, medications, in-office therapy, treatments, oral orthotics (eg splints, mouthpieces), ice/heat, etc

1. I do not need to use treatment of any type in order to control or tolerate headache, face, or jaw pain and discomfort.
2. I can completely control my pain with some form of treatment.
3. I get partial, but significant, relief through some form of treatment.
4. I don't get "a lot of" relief from any form of treatment.
5. There is no form of treatment that helps enough to make me want to continue.

SECTION 9-Tinnitus, or ringing in the ear (s)

1. I do not experience ringing in my ear (s).
2. I experience ringing in my ear (s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
3. I experience ringing in my ear (s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
4. I experience ringing in my ear (s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
5. I experience ringing in my ear (s) and is incapacitating and/or forces me to use a masking device to get any sleep.

SECTION 10-Dizziness (lightheaded, spinning, and/or balance disturbance)

1. I do not experience dizziness.
2. I experience dizziness, but it does not interfere with my daily activities.
3. I experience dizziness, which interferes somewhat with my daily activities.
4. I experience dizziness , which causes a marked impairment in the performance of my daily activities.
5. I experience dizziness, which is incapacitating