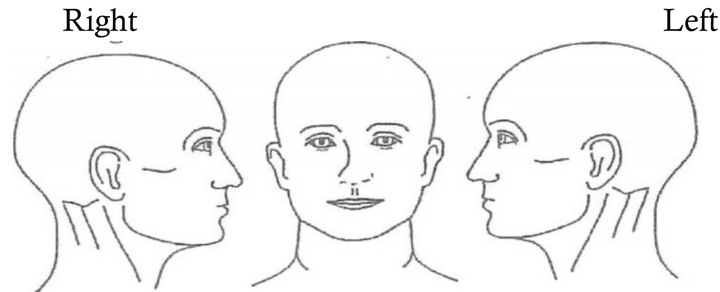
Jon Van Slate DDS, FAGD, LVIF, FIAPA

Initial Patient Workup-TMJ/TMD

Patient Name: ________________________________ Date: ____________________

1. On the diagram, please shade the areas of you pain:



2. When did your pain/problem begin? ____
3. What seemed to cause it to start? ____
4. What makes it feel worse? ____
5. What makes it feel better? ____
6. What treatments have you received? ____
7. When is your pain the worst?
   - When first wake up
   - Later in the day
   - No daily pattern
   - Other: Please explain ____
8. What does the pain keep you from doing? ____
9. Is your pain (check as many as apply)
   - ☐ Ache ☐ Throbbing
   - ☐ Pressure ☐ Burning
   - ☐ Dull ☐ Sharp
   - ☐ Other:

   Explain:____

10. Does your pain:

    Awake you at night? Yes No

    Increase when you lie down? Yes No

    Increase when you bend forward? Yes No

    Increase when you drink hot or cold beverages? Yes No
11. Please indicate 0-10 your present pain level, 10 being the worst pain imaginable: __________

12. Please indicate your average pain level during the past 6 months – 0 being no pain at all and 10 being worst pain imaginable: ___________

13. Is your pain always present? Yes No

- ➢ How often do you have pain? ____

14. Please describe any symptoms other than pain that you associate with your problem

*____

*____

*____

15. Have you had any of the following:

Head or Neck Surgery? Yes No

Whiplash or Trauma to your Head or Neck? Yes No

Shingles on Head or Neck? Yes No

16. Do you have any of the following: (please circle your answer to each question)

- A fever? Yes No
- Nasal Congestion or Stuffiness? Yes No
- Movement difficulties of facial muscles, eyes, mouth or tongue? Yes No
- Numbness or Tingling? Yes No
- Problems with your teeth? Yes No
- Swelling over your jaw joint or in your mouth or throat? Yes No
- A certain spot that triggers your pain? Yes No
- Recurrent swelling or tenderness of joints other than in your jaw joint? Yes No
- Morning stiffness in your body, other than with your jaw? Yes No

17. Is your problem worse:

- When swallowing or turning your head? Yes No
- After reading or straining your eyes? Yes No

18. Do your jaw joints make noise? Yes No

19. Have you ever been unable to open your mouth wide?

20. Have you ever been unable to close your mouth? Yes No

- Please explain: ____

21. Do you sleep well at night? Yes No If no, please explain: __________________________________

____.

22. How often are you tense, aggravated or frustrated during a usual day?

Always Never Half the time Seldom

23. How often do you feel depressed during a usual day?

Always Never Half the time Seldom

24. Do you have thoughts of hurting yourself or committing suicide? Yes No

25. Do you play a musical instrument and/or sing more than 5 hours in a typical week? Yes No

26. What percent of the day are your teeth touching? _________%

27. Are you aware of clenching or grinding your teeth?

When sleeping

While driving

When using a computer

Other: ___________________________ Not aware

28. Are you aware of oral habits such as: (check all that apply)?

- ☐ Chewing your cheeks
- ☐ Chewing objects
- ☐ Biting your nails or cuticles
- ☐ Thrusting your jaw forward
- ☐ Other habits: ______________________________
- ☐ Not aware

29. What treatment do you think is needed for you problem?

____.

30. Is there anything else you think we should know about your problem?

____.

31. If your age is 50 or older, please circle the correct response:

Does your pain occur only when you eat? Yes No

Are you pain free when you open wide? Yes No

Do you have unexplainable or unintentional weight loss? Yes No

Do you have significant morning stiffness lasting more than ½ hour? Yes No

Do you have visual symptoms or visual loss? Yes No

To the best of my knowledge, the above information is correct, and permission is granted for written report to be sent to my referring and treating doctors and dentist.

______________________________ ______________________________

Patient/Guardian Signature Date

______________________________ ______________________________

Doctor Signature Date

TMJ Disc Displacements