Patient Name: DOB: DOS:

Rate the Following from 1-10 (one being less 10 being most painful):

Facial Pain:
Headaches:
Jaw Pain:
Ear Pain:
Neck Pain:
Front/Back Head Pain:

Pain Spreads to When Having Pain: Temple, Sensitivity to Light, Vomiting, Back of Head, Nausea, Dizziness

Temporomandibular Joint Disorder (TMJ/TMD) & Pain Concerns					
Symptom Questions	Right Side	Left Side		Right Side	Left Side
Migraine Headaches	☐	☐	Pain in facial area	☐	☐
Do you have pain around/behind the eyes?	☐	☐	Grating sound in joint	☐	☐
Pain in jaw	☐	☐	Subjective hearing loss	☐	☐
Pain in neck	☐	☐	Dizziness (vertigo)	☐	☐
Pain in shoulder	☐	☐	Upset stomach- nausea	☐ Yes	☐ No
Ringing sound in ears (tinnitus)	☐	☐	Fullness, pressure	☐ Yes	☐ No
Do you have pain in the ear?	☐	☐	blockage in ear/congestion	☐ Yes	☐ No
Pain in forehead	☐	☐			

Other Pain Questions				
Circle the kind of pain you have:	☐ Sharp	☐ Spreading	☐ Aching	☐ Deep
	☐ Dull	☐ Superficial	☐ Pulsating	☐ Burning
Is the pain?	☐ Constant	☐ Intermittent		
Does the pain last for	☐ Minutes	☐ Hours	☐ All day	
Does the pain start Suddenly?		☐ Gradually		
Does the pain stop suddenly		☐ Gradually		
What time of the day or night is the pain the most severe				
How often do you have pain?	Monthly	Daily	Weekly	
What medication(s), if any, do you take to relieve the pain or have you tried?				
Does rest increase or decrease the pain?				
Please describe any method of positioning the jaw or head that you have found for relieving pain:				

Do any of the following normal daily activities cause pain? If yes, indicate where you feel pain.			
☐ Yawning	☐ Swallowing	☐ Brushing	☐ Moving shoulders
☐ Chewing	☐ Speaking	☐ Moving head	☐ Moving arms
☐ Singing	☐ Shouting	☐ Moving neck	☐ Moving trunk

Advanced Sleep
AND TMJ CENTERS

Sleep Well Carolinas!

Dedicated Sleep

Patient Name: DOB: DOS:

DYSFUNCTION			
Can you open your mouth normally?	☐ Completely	☐ Partially	
Do you ever open so wide your mouth locks open?		☐ Yes	☐ No
Do you have any of these sounds in the joint?	☐ Snapping	☐ Grating	
If you have any of these problems is it frequent?		☐ Yes	☐ No
		☐ Yes	☐ No

MISCELLANEOUS AND ASSOCIATED COMPLAINTS AND QUESTIONS		
Are your jaw muscles ever tired?	☐ Yes	☐ No
Have you had any injury to the jaw or face? If yes, explain.	☐ Yes	☐ No
Do you attribute the symptoms to any one incident?	☐ Yes	☐ No
Have you had cortisone injected into the joint? If yes, when?	☐ Yes	☐ No
How many injections? By whom?	☐ Yes	☐ No
Do you know if you clench your teeth?	☐ Yes	☐ No
Has anyone mentioned that you grind your teeth (brux) at night during sleep?	☐ Yes	☐ No
Have you had any other treatment for this problem? (*If yes, explain-medicine, exercise, dental treatment)*		
Have you had your bite adjusted by your dentist? (*If yes, please explain when)*	☐ Yes	☐ No
How long have you been bothered by this problem?		
Is there anyone else in your family with a similar problem? (*If yes, explain)*		

Please describe briefly any changes in location or character of symptoms since this problem began

Do you chew gum?	Frequently	Moderately	Infrequently	Never