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		Number #1 = the most severe symptom	
☐	Jaw pain	☐	Morning head pain
☐	Jaw clicking	☐	Ringing in the ears
☐	Jaw locking	☐	Dizziness
☐	Limited mouth opening	☐	Nocturnal teeth grinding
☐	Facial pain	☐	Frequent Heavy Snoring
☐	Neck pain	☐	Pain when chewing
☐	Headaches		
☐	Migraines		

Other: Write In

Symptoms

HEAD PAIN

Unsupported Control
Unsupported Control
Unsupported Control
Unsupported Control
Unsupported Control

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

☐ Jaw locks open

☐ Teeth grinding

MOUTH AND NOSE RELATED CONDITION

Patient Signature: Date:

Symptoms

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
- ☐ Pain behind the ear

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

Other

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)

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:

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: _____

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: _____

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:

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 lefft 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: _____

Head Pain History

Pain Qualities

--- LOCATION ---

Which side are the headaches worse?

- ☐ both sides
- ☐ the left side
- ☐ the right side
- ☐ _____

Headache spreads to

- ☐ the temple
- ☐ the back of the head
- ☐ the temple
- ☐ the back of the head
- ☐ the forehead
- ☐ _____

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

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

☐ 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

FREQUENCY

- ☐ occasional (0-3/mo)
- ☐ frequent (3-6/mo)
- ☐ constant
- ☐ _____

--- DURATION ---

- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Weeks

When having pain do you experience:

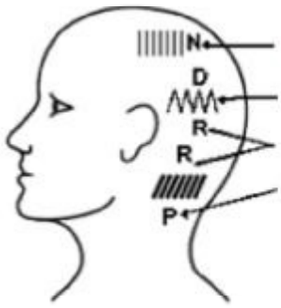
- ☐ Dizziness
- ☐ Double vision
- ☐ Fatigue
- ☐ Nausea
- ☐ Sensitivity to light (photophobia)
- ☐ Sensitivity to noise
- ☐ Throbbing
- ☐ Vomiting
- ☐ Burning

Other _____ _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN	|||||||	B Burning D Dull N Numbing P Pressure S Sharp T Tingling R Radiating
MODERATE PAIN	/\/\/\	
SEVERE PAIN	//////	

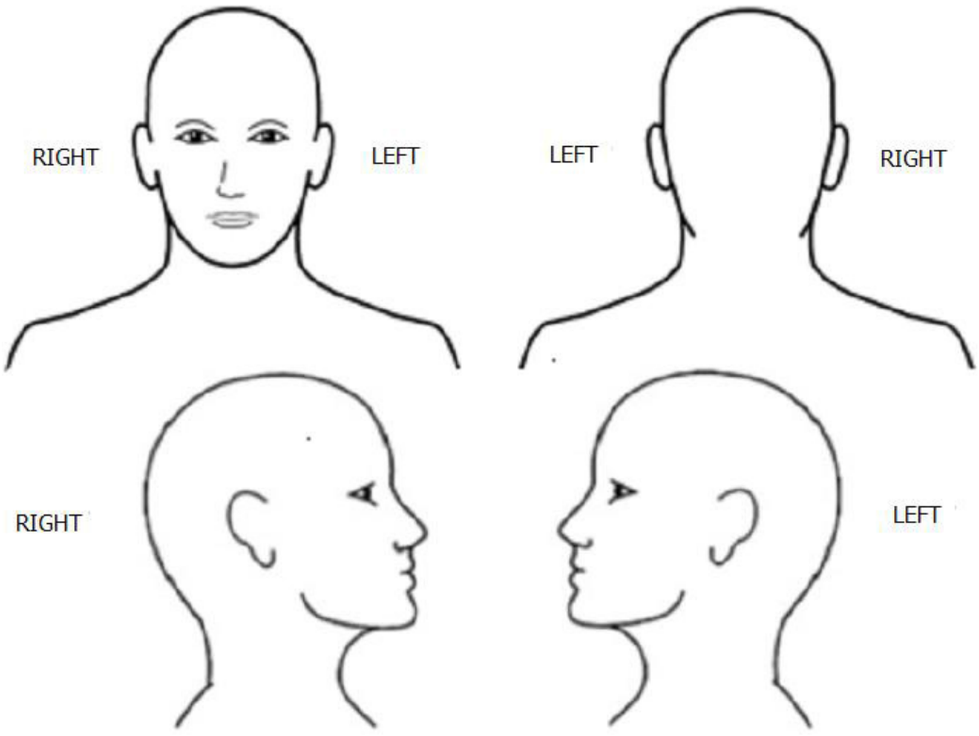


Mild, numbing pain

Moderate, dull pain

Severe, radiating pain

Pressure



Enter any text to appear below the image:

Patient Signature: Date:

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: