Dear Patient,

To help us better treat you, please fill out the form below as best to your ability.

Using the scale below, please rate your pain
(0) No pain (1) mild (2) moderate (3) severe

_____headache _____facial pain _____neck pain _____shoulder pain
_____tooth pain _____ear pain _____joint noise _____inability to chew
_____bite feels off _____pain w/ opening _____jaw locks
_____other ____ open ____closed

Please check off medication you are taking

_____pain reliever (over the counter)
_____pain reliever (prescription)
_____anti-inflammatory (over the counter)
_____anti-inflammatory (prescription)
_____muscle relaxants
_____anti-depressants
_____other

Physical Therapy

_____I receive physical therapy _____I do not receive physical therapy
____more than once a week
____once (1) a week
____bi-weekly
____monthly
____other

How often does your TMJ pain limit your activities?

____never _____once a week ____2-3 times a week
____once a month _____several days a week ____daily

How often does jaw stiffness, limited motion or weakness limit your activities?

____never _____once a week ____2-3 times a week
____once a month _____several days a week ____daily

How does your TMJ disorder limit your ability to work?

____no limitations _____slightly _____moderately
____greatly limits me _____totally limits me

How does your TMJ disorder what you can eat?

____no limitations _____slightly _____moderately
____greatly limits me _____totally limits me

How your overall quality of life been compromised due to your TMJ disorder?

_____somewhat compromised
_____greatly compromised
_____totally compromised

_____

Patient's Signature Date