TMJ Disorder Patient Questionnaire

Personal Information

Full Name

Date of Birth

Phone Number

Email

Medical History

How long have you experienced jaw problems or pain?

Have you had any previous treatment for TMJ disorder?

- ○ Yes
- ○ No

If yes, please describe the treatment:

Please list any other medical conditions you have:

Symptoms

Which of the following symptoms do you experience? (check all that apply)

- ☐ Jaw pain
- ☐ Clicking or popping noises
- ☐ Locking of the jaw
- ☐ Headaches
- ☐ Ear pain
- ☐ Difficulty chewing

Other symptoms:

Pain Assessment

On a scale of 0-10, what is your average jaw pain?

Where is the pain located?

How often do you experience pain?

What activities trigger your jaw pain?

Lifestyle & Habits

Do you clench or grind your teeth?

- Yes
- No
- Unsure

Do you have any history of jaw injury?

- Yes
- No

If yes, please provide details:

Additional Notes

Please provide any other information that may help us with your assessment: