

**Marianne Schaefer, D.D.S.**  
**TMJ PROBLEM QUESTIONNAIRE**

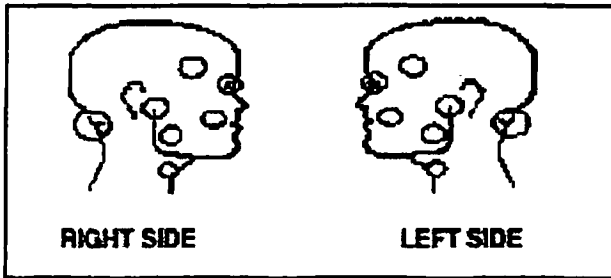
**PLEASE ANSWER ALL QUESTIONS**

**DO NOT WRITE IN THIS SPACE**

I. Name \_\_\_\_\_ Age \_\_\_\_\_  
 Date \_\_\_\_\_ Referred by \_\_\_\_\_

II. Which of the following do you have (circle all that apply)  
 Headaches    Neck pain    Jaw pain    Ear pain  
 Facial pain    Other \_\_\_\_\_  
 Which side hurts (circle one)    Right    Left    Both  
 Comments \_\_\_\_\_

III. Place an (X) in the circle (s) where you hurt.



IV. How long have you had this pain? \_\_\_\_\_  
 Is the pain constant? \_\_\_\_\_  
 Is the pain (circle all that apply)    Aching    Burning  
 Stabbing    Other \_\_\_\_\_

V. Is the pain the worst in the (circle all that apply)  
 Morning    Afternoon    Evening    Night

VI. Have you ever injured or sustained any form of trauma or whiplash  
 to your (circle all that apply)  
 Jaw    Head    Neck  
 (If so, please complete the trauma questionnaire)

VII. \_\_\_\_\_ What makes the pain better?

\_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

\_\_\_\_\_

What medication(s) do you take or have you previously taken for  
 your pain?

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_

**Marianne Schaefer, D.D.S.**  
**TMJ PROBLEM QUESTIONNAIRE - Page 2**

Your Name: \_\_\_\_\_

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE
VIII. Does it hurt to chew? <span style="float: right;">Y    N</span>	
Does it hurt to open wide? <span style="float: right;">Y    N</span>	
Which side of your jaw makes a popping noise? <span style="float: right;">L    R</span>	
Which side of your jaw makes a clicking noise? <span style="float: right;">L    R</span>	
Which side of your jaw makes other noises? <span style="float: right;">L    R</span>	
What noises? _____	
When did you first notice joint noises? _____	
IX. Has your jaw ever locked? <span style="float: right;">Y    N</span>	
Did it lock open or closed? (circle one) <span style="float: right;">Open    Closed</span>	
When did this first happen? _____	
When did this last happen? _____	
Has your jaw ever slipped out of place? <span style="float: right;">Y    N</span>	
Which side? <span style="float: right;">R    L</span>	
X. Have you noticed a change in your bite? <span style="float: right;">Y    N</span>	
Did you notice a change at your front teeth? <span style="float: right;">Y    N</span>	
Did you notice a change at your back teeth? <span style="float: right;">Y    N</span>	
Has your profile changed? <span style="float: right;">Y    N</span>	
Have you noticed any crookedness or asymmetry in your jaw? <span style="float: right;">Y    N</span>	
When did you notice the asymmetry? _____	
XI. Are your teeth sore or sensitive? <span style="float: right;">Y    N</span>	
Do you clench your teeth? <span style="float: right;">Y    N</span>	
Do you grind your teeth? <span style="float: right;">Y    N</span>	
Do you do this during the day or night? <span style="float: right;">Day    Night</span>	
When did you start clenching or grinding? _____	
XII. Do you have problems with your ears? _____	
Dizziness? Y N    Ringing Y N	
Hearing? Y N    Other? _____	
XIII. Is it difficult to swallow? <span style="float: right;">Y    N</span>	
Is it painful to swallow? <span style="float: right;">Y    N</span>	
Have you noticed lumps in your face? <span style="float: right;">Y    N</span>	
Throat? Y N    Neck? Y N	
Other? _____	

**Marianne Schaefer, D.D.S.**  
**TMJ PROBLEM QUESTIONNAIRE - Page 3**

Your Name: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS**

**DO NOT WRITE IN THIS SPACE**

XIV. Have you had any prior treatment for TMJ?    Y        N

Splint?            Y    N    When? \_\_\_\_\_

Did it help        Y    N

Nightguard?      Y    N    When? \_\_\_\_\_

Did it help        Y    N

Bite Adjustment Y    N    When? \_\_\_\_\_

Did it help        Y    N

Orthodontics?    Y    N    When? \_\_\_\_\_

Did it help?      Y    N

Other? \_\_\_\_\_

XV. Describe the problems in your own words as you understand them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

XVI. Reports may be sent to my:

Medical doctor \_\_\_\_\_

Dentist \_\_\_\_\_

Other \_\_\_\_\_

XV. I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing. I consent to the use of my x-rays, records and photos for Scientific publication or teaching providing my name remains anonymous.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date