

LOMA LINDA UNIVERSITY CENTER FOR DENTISTRY AND ORTHODONTICS
TMJ QUESTIONNAIRE

Name: _____

Today's Date: _____

1. What is your current pain rating? (Please circle) 0 1 2 3 4 5 6 7 8 9 10
2. Where is the pain located? _____
3. What is the frequency of the pain? _____
4. When you have the pain, how long does it last? _____
5. Are you taking medications for pain?..... Yes No
Explain: _____
6. Do you notice any clicking or popping in your jaw? Yes No
Explain: _____
7. Do you notice that you are clenching or grinding during the day or at night? Yes No
Explain: _____
8. Do you experience locking of your jaw?..... Yes No
Closed or open position _____ Duration _____ Frequency _____
What was done to unlock it? _____
9. Do you experience headaches?..... Yes No
Type of headaches _____ Duration _____ Frequency _____
10. Are you doing exercises for TMJ?..... Yes No
Explain: _____
11. Are you using ethyl chloride? Yes No
Explain: _____
12. Are you doing physical therapy?..... Yes No
Who do you see? _____ Is it helping? _____ # of sessions done _____ # left _____
13. Are you using hot/cold packs? Yes No
Explain: _____

Anything else you would like to share with the doctor? _____

