Antioch Dental Care
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Temporomandibular Joint (TMJ) Questionnaire

If you are experiencing any of the following symptoms please complete this questionnaire.

Headaches; noisy (clicking) joints in front of both ears; your bite does not feel right; flat or worn teeth; sensitive back teeth; feeling of fullness in ears:

Name____Date______________________

Address____Date of Birth___________________

Which aspects of your TMJ problem concern you the most? ___________________________________
____
____

Please circle the correct response where applicable.

Have you received previous treatment for this problem? Yes No
When?____________________________Where?________________________

Have you ever had a severe blow or trauma to the head, neck or jaw? Yes No
When ?____________________________Which area?____________________
Explain____

Do you have frequent headaches or neck aches? Yes No
What area?_________________________
How frequent?______________________
How do you control the pain?____

Do you have difficulty chewing? Yes No

Because of:	pain in joint	limited opening	pain in teeth
	Missing teeth	clicking	other (explain)

Has your mouth ever locked open so you were unable to close it? Yes No
Explain____

Has your mouth ever locked closed? Yes No
Explain____

Are you aware of clenching your teeth? Yes No

Do you grind your teeth? Yes No
When?____

Have you had recent dental treatment? Yes No
When?____________________________Where?________________________
Explain____

Have you had orthodontic treatment? Yes No
When?____________________________Where?________________________