Version: TMDQV1

TMJ Screening Consultation Questionnaire

OFFICE USE
Patient ID:____

NAME: ____________________ __ ____________________

CURRENT DATE: ____/____/______

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

Referring Physician: ____________ Contact ID: ____________

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

Number
#1 = the most severe symptom

- ☐ Jaw pain
- ☐ Jaw clicking
- ☐ Jaw locking
- ☐ Limited mouth opening
- ☐ Facial pain
- ☐ Neck pain
- ☐ Headaches
- ☐ Migraines

Number
#1 = the most severe symptom

- ☐ Morning head pain
- ☐ Ringing in the ears
- ☐ Dizziness
- ☐ Frequent Heavy Snoring
- ☐ Pain in or around ear
- ☐ Pain when chewing

Other: Write In

____________________ ____________________

____________________ ____________________

Symptoms

HEAD PAIN

L R B Front of your head (Frontal)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

L R B Entire head (Generalized)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

L R B Top of your head (Parietal)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

L R B Back of your head (Occipital)

Severity			Frequency			Duration				
Mild	Mod	Severe	Occas.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

Patient Signature: ____________________ Date: __________