MOUNTAINS
TMJ & DENTAL
SLEEP MEDICINE

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TMJ Disorders Screening

Patient Name: ____ **Date:** ____/____/_____

Address: ____ **DOB:** ____/____/_____

Section 1: TM Joint Symptoms

Please tick one yes or no response for each question.

	No	Yes
Do you regularly have clicking or popping noises in your jaw joints TMJs)?	❑	❑
Do you regularly feel pain in or around your Jaw Joints (TMJs)?	❑	❑
Does you jaw ever lock open or closed?	❑	❑
Do your jaws become sore or tired while eating a normal meal?	❑	❑

Section 2: Subjective TMJ & Muscle Evaluation

Please tick one yes or no response for each question.

	No	Yes
Do you suffer with headaches?	❑	❑
Are the headaches hormone related?	❑	❑
Do you have headaches above or behind the eyes?	❑	❑
Do you wake up at night or in the mornings with headaches?	❑	❑
Do headaches wake you during the night?	❑	❑
Do you clench or grind your teeth during the night?	❑	❑
Do you have pain or soreness at the back of the head – occipital region?...............	❑	❑
Do you suffer neck or shoulder pain?	❑	❑
Can you comfortably turn your head all the way to both sides?	❑	❑
Do you have high blood pressure?	❑	❑

Section 3: Prior TMD Diagnosis

Fill in the blanks, tick one yes or no response for each question

	No	Yes
Have you previously been diagnosed with TMJ Disorder?	❑	❑
If Yes: When were you diagnosed? (Approx mo/yr) ___________		
Were you recommended splint or Orthotic therapy?	❑	❑
Are you still using you're a splint or Orthotic?	❑	❑

Notes: (Please add any notes regarding Temporomandibular Joints or Orofacial Pain that you feel may be appropriate.)

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Joint Symptoms ______. Subjective TMJ Eval ______ Prior TMJD Diagnosis ______ Referral Recommended ❑

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