TMD/CMD Questionnaire

Name: _____ Date: _____

Instead of the 1-10 rating scale, we will just have Mild, Moderate, Severe as choices

Symptoms

- **Please check any existing symptoms and grade their severity and frequency**

Select one that best describes:
daily/most days/weekly/monthly

O	Headaches/Migraines	**L**	**R**	0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	TMJoint pain	**L**	**R**	0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	TMJ noise	**L**	**R**	O clicking			O popping			O grinding					Frequency _____
•	Muscle Pain														
	O Cervical/Neck	**L**	**R**	0	1	2	3	4	5	6	7	8	9	10	Frequency _____
	O Shoulders	**L**	**R**	0	1	2	3	4	5	6	7	8	9	10	Frequency _____
	O Jaw	**L**	**R**	0	1	2	3	4	5	6	7	8	9	10	Frequency _____
	O Temples	**L**	**R**	0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	Ear congestion/deafness			0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	Vertigo (dizziness)			0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	Tinnitus (ringing/noise in the ears)			0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	Dysphagia(difficulty swallowing)			0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	Clenching/Bruxing			0	1	2	3	4	5	6	7	8	9	10	Frequency _____
O	Facial pain (non-specific)			0	1	2	3	4	5	6	7	8	9	10	Frequency _____

O Tender/sensitive teeth
O Loose teeth
O Limited opening
O Difficulty chewing
O Postural problems
O Paresthesia of fingertips (tingling)
O Thermal sensitivity (hot and/or cold)
O Trigeminal neuralgia
O Bell's palsy
O Nervousness/Insomnia

What is your chief concern? .....

.....

Duration of symptoms .....

Any prior treatment? .....

- Bite raising appliance (splint) YES / NO
- Pain medication: Type ..... Frequency .....

Duration of Therapy .....

Type of Therapy .....

Overall Symptom Improvement (OSI) ..... %

Additional comments:

.....

.....

.....

.....

.....

.....

.....

.....