Name_____ Date_____ Patient # _____

TMJ Disability Index

Please read carefully:

Please mark the one choice that best pertains to you (not necessarily exactly) in each of the following categories.

Section 1 – Communication (talking)

☐ I can talk as much as I want without pain, fatigue or discomfort.

☐ I talk as much as I want, but it causes some pain, fatigue and/or discomfort.

☐ I can't talk as much as I want because of pain, fatigue and/or discomfort.

☐ Pain prevents me from talking at all.

Section 2 – Normal living activities (brushing teeth/flossing)

☐ I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort

☐ I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.

☐ I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort. Jaw tiredness no matter how slow and careful I am.

☐ I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.

☐ I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

Section 3 – Normal living activities (eating, chewing)

☐ I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.

☐ I can eat and chew most anything I want, but it sometimes causes pain/discomfort, and/or jaw tiredness.

☐ I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.

☐ I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.

☐ I must stay on a liquid diet because of pain and/or restricted opening.

Section 4 – Social/Recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, recreation, etc.)

☐ I am enjoying a normal social life and/or recreational activities without restriction

☐ I participate in normal social life and/or recreational activities but pain/discomfort is increased.

☐ The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instruments, singing).

☐ I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.

☐ I have practically no social life because of pain.

Section 5 – Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide)

☐ I can yawn in anormal fashion, painlessly.

☐ I can yawn and open my mouth fully wide open, but sometimes there is discomfort.

☐ I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.

☐ Yawning and opening my mouth wide are somewhat restricted by pain.

☐ I cannot yawn or open my mouth more than two finger widths (2.8-3.2cm) or, if I can, it always causes greater than moderate pain.

Section 6 – Sexual function (including kissing, hugging, and any and all sexual activities to which you are accustomed)

☐ I am able to engage in all my customary sexual activities and expressions without limitations and/or causing headache, face or jaw pain.

☐ I am able to engage in all my customary sexual activities and expressions, but it sometimes causes some headache, face or jaw pain or jaw fatigue.

☐ I am able to engage in all my customary sexual activities, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.

☐ I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.

☐ I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

Section 7 – Sleep (restful, nocturnal sleep pattern)

☐ I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.

☐ I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aids.

☐ I fail to realize 6 hours of restful sleep even with the use of pills.

☐ I fail to realize 4 hours of restful sleep even with the use of pills.

☐ I fail to realize 2 hours of restful sleep even with the use of pills

Section 8 – Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatments, oral orthotics (e.g., splints, mouthpieces), ice/heat, etc.

☐ I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.

☐ I can completely control my pain with some form of treatment.

☐ I get partial, but significant, relief through some form of treatment.

☐ I don't get "a lot of" relief from any form of treatment.

☐ There is no form of treatment that helps enough to make me want to continue.

Section 9 – Tinnitus or ringing in the car (s).

☐ I do not experience ringing in my ear(s).

☐ I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.

☐ I experience ringing in my ear(s) and it interferes with my sleep and/or activities, but I can accomplish set goals and I can get an acceptable amount of sleep.

☐ I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.

☐ I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

Section 10 – Dizziness (lightheaded, spinning and/or balance disturbance)

☐ I do not experience dizziness.

☐ I experience dizziness, but it does not interfere with my daily activities.

☐ I experience dizziness, which interferes somewhat with my daily activities, but I can accomplish my set goals.

☐ I experience dizziness, which causes a marked impairment in the performance of my daily activities.

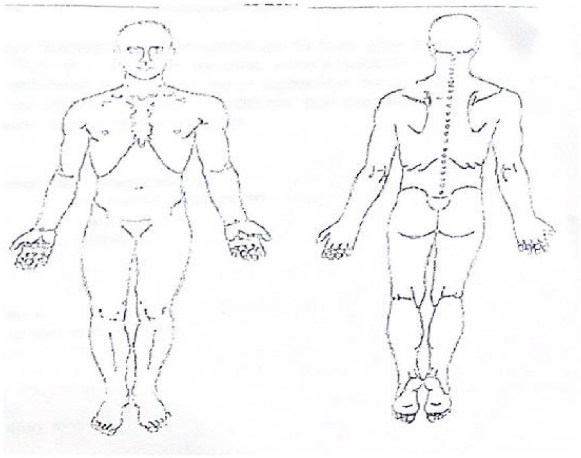
☐I experience dizziness, which is incapacitating.

Pain and Symptom Status Report

Name_____ Date_____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
MMM	__ __ __ __	() () () () ()	NNNNN	/ / / / /	x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is:_____

Date First Symptom of your problem occurred on:_____

2nd Complaint: _____

3rd Complaint: _____

Please mark on scale below to indicate your <u>CURRENT</u> level of pain: No pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Pain as bad as it gets
Please mark on scale below to indicate your <u>AVERAGE</u> level of pain: No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Pain as bad as it gets
Please mark scale below to indicate your <u>WORST</u> level of pain: No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Pain as bad as it gets