

Myofascial Pain Examination

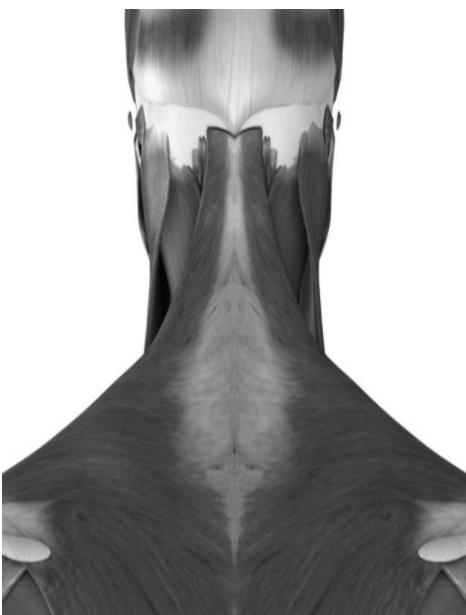
Patient Name:	Date:	Provider:
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TMJ Examination

1. TMJ movement on opening	Right: Left:	<input type="checkbox"/> normal <input type="checkbox"/> normal	<input type="checkbox"/> limited <input type="checkbox"/> limited	<input type="checkbox"/> closed lock <input type="checkbox"/> closed lock	<input type="checkbox"/> locks open <input type="checkbox"/> locks open
2. TMJ lateral pole tenderness	Right: Left:	<input type="checkbox"/> normal <input type="checkbox"/> normal	<input type="checkbox"/> mild <input type="checkbox"/> mild	<input type="checkbox"/> moderate <input type="checkbox"/> moderate	<input type="checkbox"/> severe <input type="checkbox"/> severe
3. TMJ sounds on right	opening click: closing click: crepitus: Is there pain associated with the TMJ sound? Click eliminated on protrusive?	<input type="checkbox"/> none <input type="checkbox"/> none <input type="checkbox"/> none <input type="checkbox"/> no <input type="checkbox"/> no	<input type="checkbox"/> reproducible <input type="checkbox"/> reproducible <input type="checkbox"/> fine <input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> non-reproducible <input type="checkbox"/> non-reproducible <input type="checkbox"/> coarse <input type="checkbox"/> no <input type="checkbox"/> no	
4. TMJ sounds on left	opening click: closing click: crepitus: Is there pain associated with the TMJ sound? Click eliminated on protrusive?	<input type="checkbox"/> none <input type="checkbox"/> none <input type="checkbox"/> none <input type="checkbox"/> no <input type="checkbox"/> no	<input type="checkbox"/> reproducible <input type="checkbox"/> reproducible <input type="checkbox"/> fine <input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> non-reproducible <input type="checkbox"/> non-reproducible <input type="checkbox"/> coarse <input type="checkbox"/> no <input type="checkbox"/> no	

Muscle Examination

Right		Left
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Trapezius	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Sternocleidomastoid	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Splenius Capitus	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Superficial Masseter	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Deep Masseter	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Anterior Temporalis	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Middle Temporalis	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer	Posterior Temporalis	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refer



Mandibular Range of Motion

1. Maximum incisal pattern on opening	<input type="checkbox"/> Straight <input type="checkbox"/> Deflection to right <input type="checkbox"/> Deflection to left <input type="checkbox"/> Deviation to left <input type="checkbox"/> Deviation to right		
2. Unassisted opening without pain	<input type="text"/>	<input type="text"/>	mm
3. Maximum unassisted opening (by patient) Normal opening 40-60mm	<input type="text"/>	<input type="text"/>	mm
Pain?	<input type="checkbox"/> no	<input type="checkbox"/> joint <input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> muscle <input type="checkbox"/> Rt <input type="checkbox"/> Lt
4. Maximum assisted opening (with stretch) Normal opening 40-60mm	<input type="text"/>	<input type="text"/>	mm
Pain?	<input type="checkbox"/> no	<input type="checkbox"/> joint <input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> muscle <input type="checkbox"/> Rt <input type="checkbox"/> Lt
5. Right lateral excursion Normal excursion 10mm	<input type="text"/>	<input type="text"/>	mm
Pain?	<input type="checkbox"/> no	<input type="checkbox"/> joint <input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> muscle <input type="checkbox"/> Rt <input type="checkbox"/> Lt
6. Left lateral excursion Normal excursion 10mm	<input type="text"/>	<input type="text"/>	mm
Pain?	<input type="checkbox"/> no	<input type="checkbox"/> joint <input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> muscle <input type="checkbox"/> Rt <input type="checkbox"/> Lt
7. Protrusion Normal excursion 10mm	<input type="text"/>	<input type="text"/>	mm
Pain?	<input type="checkbox"/> no	<input type="checkbox"/> joint <input type="checkbox"/> Rt <input type="checkbox"/> Lt	<input type="checkbox"/> muscle <input type="checkbox"/> Rt <input type="checkbox"/> Lt

Recommendations

Injections	<input type="checkbox"/> Botox Injections <input type="checkbox"/> Nerve Block <input type="checkbox"/> TMJ
Splint/Orthotic	<input type="checkbox"/> Type:
Self-Care	<input type="checkbox"/> Exercise Diary <input type="checkbox"/> Oral Habits <input type="checkbox"/> Pain
Medication	<input type="checkbox"/> Anti-Inflammatory Chloride Spray <input type="checkbox"/> Muscle Relaxant <input type="checkbox"/> Ethyl
Imaging	<input type="checkbox"/> Refer <input type="checkbox"/> Other:
Physical Therapy	<input type="checkbox"/> Refer to evaluate and treat <input type="checkbox"/> Exercise: <input type="checkbox"/> Postural <input type="checkbox"/> 6 by 6 <input type="checkbox"/> Stretching <input type="checkbox"/> Relaxation
Behavioral Health	<input type="checkbox"/> Refer <input type="checkbox"/> Other:
TMJ Surgery	<input type="checkbox"/> Refer <input type="checkbox"/> Other:

Diagnosis (check all that apply)

R L Joint Disorders <input type="checkbox"/> TMJ Ankylosis and Adhesions M26.61 <input type="checkbox"/> TMJ Arthralgia and Inflammation M26.62 <input type="checkbox"/> TMJ Disc Disorder (reducing) M26.63 <input type="checkbox"/> TMJ Disc Disorder (non-reducing) M26.63 <input type="checkbox"/> TMJ Dislocated Jaw, closed lock S03.0XXA <input type="checkbox"/> TMJ Dislocated Jaw, open lock S03.0XXA <input type="checkbox"/> TMJ Osteoarthritis, local & 1° M19.91 <input type="checkbox"/> TMJ Rheumatoid Arthritis M15.0 <input type="checkbox"/> TMJ Traumatic Arthropathy M12.58 <input type="checkbox"/> TMJ Strain/Sprain from Overuse S03.4XXA <input type="checkbox"/> TMJ Implant Failure M26.61 <input type="checkbox"/> TMJ Tumor Benign D16.5 <input type="checkbox"/> TMJ Tumor Other: _____	Muscle Disorders <input type="checkbox"/> Muscle Spasm M62.40 <input type="checkbox"/> Myofascial Pain: Masticatory M60.9 <input type="checkbox"/> Myofascial Pain: Cervical M60.9 <input type="checkbox"/> Fibromyalgia/Chronic fatigue M79.7 Headache <input type="checkbox"/> Migraine with Aura G43.109 <input type="checkbox"/> Migraine without Aura G43.009 <input type="checkbox"/> Cluster Headache G43.811 <input type="checkbox"/> Tension-Type Headache G44.209 <input type="checkbox"/> Rebound/Transformed R51	Neuropathic <input type="checkbox"/> Trigeminal Neuralgia G50.0 <input type="checkbox"/> Atypical Face Pain G50.1 <input type="checkbox"/> Glossodynia/ Burning Mouth K14.6 Other <input type="checkbox"/> Orofacial Dyskinesia G24.4 <input type="checkbox"/> Bruxism/Teeth Grinding F45.8 <input type="checkbox"/> Psychological Factors F54 <input type="checkbox"/> Anomalies of Jaw Size M26.00 <input type="checkbox"/> List:
Referral		
Provider:	Date:	