TMD Assessment

Name _____ Age _____ Date _____

Dentist _____ Orthodontist _____

What symptoms do you have presently? Check all that apply:

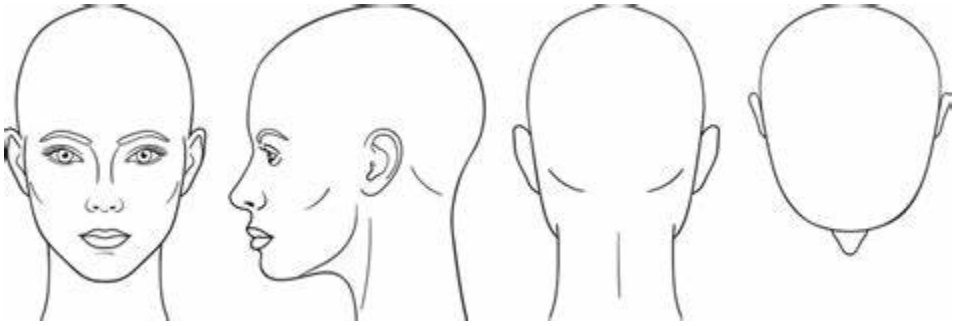
☐ Jaw pain	☐ Headaches	☐ Neck and shoulder pain
☐ Clicking or noise in the jaw	☐ Clenching during the day	☐ Clenching during sleep
☐ Grinding during sleep	☐ Difficulty opening your mouth	☐ Jaw locks open or shut
☐ Pain in teeth	☐ Tired or sore jaw upon waking	☐ Ringing or noise in ears
☐ Sinus pain	☐ Difficulty hearing or ear stuffiness	☐ Pressure behind the eyes
☐ Dizziness/Vertigo	☐ Difficulty sleeping	☐ Sleep Apnea
☐ Mouth breathing	☐ Tongue Tie	☐ Digestive Issues

☐ Frequent earaches with no infection present

Jaw pain occurs during ☐ opening mouth ☐ chewing ☐ talking ☐ other

How long have you experienced these problems? _____
What helps? _____
What makes it worse? _____
Physical Trauma to jaw, face, head or neck:_____
Surgery: _____
Is it worse in the AM or PM?
Does your pain increase with fatigue or is all at once a sharp pain? _____
Have you seen any other practitioners about this condition? _____
What did they do? _____

Mark the areas you experience pain/discomfort Notes



Area affected/Level of Discomfort (1-5)

Pain at TMJ	Left	Y/N		Right	Y/N
Pain in ear canal	Left	Y/N		Right	Y/N
Clicking	Left	Y/N		Right	Y/N
Mandible Compression	Y/N				
Mandible Protrusion	Y/N				

Condylar Synchronization _____
Jaw ROM (40/50 regular): Before: _____After: _____
Open as far as possible Before: _____After: _____
Lateral Shift(10-15)R: Before: _____After: _____
Lateral Shift(10-15)L: Before: _____After: _____
Deviation (Swerve) or Deflection (Pull to side) _____
Tongue Tie Anterior Posterior