

TMJ History

Name: _____

Date: _____

Please Check the box if you have the pain with the following questions. Your answers will help to maximize our evaluation of your current condition to narrow down your diagnosis and treatment.

Do you have or had ...

- Pain with opening your mouth
- Pain with closing your mouth
- Pain with fully opening your mouth
- Pain with biting down on an object
- Pain with eating
- Pain with chewing
 - Right Left
- Stiffness on waking that eases as the day goes by
- Pain with yawning
- Clicking of your jaw
 - Right Left
- Locked jaw
 - Right Left
- Wear a dental splint/night guard
- Neck pain/injury
- Headaches

Do you have any of these habits?

- Smoking
- Leaning on your chin
- Chewing gum
- Biting of your nails
- Holding a phone with your shoulder
- Clenching and/or grinding

Have you had any recent and/or past oral surgery?

Surgeries	Date	Reason

What are your current symptoms causing difficulty with in your daily life?

What are your goals for physical therapy for your jaw pain?
