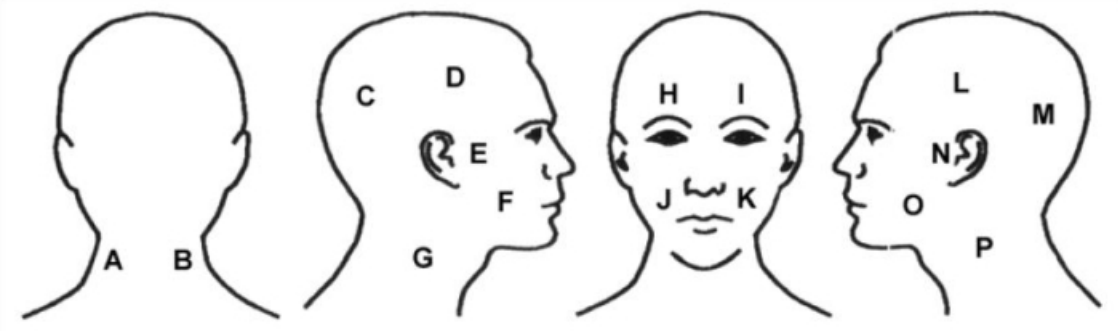
TMJ INITIAL EXAM FORM

WHAT IS THE MAIN REASON YOU ARE HERE?

__Bruxism	__Grating Jaw Noises	__Muscle Pain	__Spontaneous TMJ Pain
__Burning Mouth	__Headaches	__Neck Pain	__Teeth don't fit
__Clenching	__Heavy Snoring	__Numbness	__Temple Pain
__Dizziness	__Jaw Locked Closed	__Oral Ulcers/Sores	__TMJ Pain on Closing
__Earaches	__Jaw Locks Open	__Painful Jaw Clicking	__TMJ Pain on Opening
__Eye Pain	__Jaw Pain	__Painless Jaw Clicking	__TMJ Pain with Chewing
__Facial Pain	__Jaw won't open wide	__Ringing in Ears	__Tongue Pain
__Forehead Pain	__Lip Pain	__Sinus Pain	__Tooth Pain

Other_____

PLEASE PLAN AN "X" ON THE PRIMARY LOCATION OF YOUR PAIN



DESCRIBE YOUR PAIN

__Aching	__Deep	__Localized	__Sudden Onset
__Annoying	__Diffuse	__Pressure	__Superficial
__Bilateral	__Dull	__Radiating	__Tightness
__Burning	__Electric-like	__Sharp	__Throbbing
__Crushing	__Gradual Onset	__Steady	

WHAT BROUGHT ON THESE COMPLAINTS?

__Following a Dental Procedure
__Following a Motor Vehicle Accident __-__-__ (Date)
__Following a Surgical Procedure
__Following Trauma to the Head
__Following Trauma to the Neck
__Spontaneously
__Following a Stressful Episode
__Of No Known Origin
__While Eating

Other_____

HOW LONG HAVE YOU HAD THESE COMPLAINTS?

__As long as I can remember
__Days
__Months
__Years
Since the age of____

Other_____

DESCRIBE THE FREQUENCY OF YOUR PAIN

__Constant __Weekly __Daily
__Intermittent __Monthly

DURATION OF EPISODES

__Seconds __Minutes __Hours __Days

WHEN IS YOUR CHIEF COMPLAINT WORST?

__At Any Time of the Day __In the Morning __When Under Stress __In the Evening
__After Eating __Midday __While Eating
__During Menstrual Cycle __Upon Awakening __Variably

Other_____

WHAT OTHER PRACTITIONERS HAVE YOU SEEN FOR YOUR CHIEF COMPLAINT?

__No Other Practitioners __Endocrinologist __Internist __Orthodontist
__Acupuncturist __Endodontist __Neurologist __Physical Therapist
__Allergist __ENT __Neurosurgeon __Psychiatrist
__Anesthesiologist __Family Physician __Optometrist __Psychologist
__Chiropractor __General Dentist __Ophthalmologist __Rheumatologist
__Dermatologist __Gynecologist __Oral Surgeon __Surgeon

Other_____

WHAT WAS THE SUCCESS OF THIS TREATMENT

__Complete __Significant
__Minimal __None

HEALTH HISTORY

MARK ALL RESPONSES YOU HAVE HAD OR CURRENTLY HAVE:

__No Related Medical Problems

__Aids	__Emphysema	__Leukemia	__Radiation Treatment
__ARC	__Fracture(s)	__Liver Disease	__Reproductive Tract Disorder
__Anemia	__Fainting/Dizziness	__Mononucleosis	__Seizures
__Anxiety	__Heart Disease	__Nervous Breakdown	__Stomach Ulcers
__Arthritis	__Heart Murmur	__Neuralgia	__Urinary Tract Problems
__Asthma	__Hemophilia	__Neurosis	__Weight Gain/Loss
__Bronchitis	__Hepatitis	__Parkinson's Disease	__Yeast (Fungus)
__Cancer	__History of Prior Surgery	__Pregnancy	
__Chemotherapy	__Hormonal Disturbance	__Psychiatric Counseling	
__Depression	__Hypertension	__Psychiologic Counseling Related to Chief Complaint	
__Dermatitis	__Hypotension	__Psychiologic Counseling Not Related to Chief Complaint	
__Diabetes	__Kidney Disease		

Other_____

PLEASE MARK THE APPROPRIATE RESPONSES

__I Feel Depressed __I Feel Anxious
__I Have Thought About Suicide __I Have Difficulty Sleeping

Other_____

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY USING FOR YOUR CHIEF COMPLAINT

_____
_____

PLEASE LIST MEDICATIONS THAT WERE PAST EFFECTIVE FOR YOUR CHIEF COMPLAINT

_____
_____

PLEASE LIST MEDICATIONS THAT WERE PAST INEFFECTIVE FOR YOUR CHIEF COMPLAINT

_____
_____

PLEASE LIST OTHER MEDICATIONS TAKEN

_____

_____

DO YOU USE TOBACCO?

__Do Not Smoke
__Smoke a Pipe Times a Day__ How Many Years__
__Smoke Cigarettes Packs a Day__ How Many Years__
__Smoke Cigars Cigars a Day__ How Many Years__
__Smokeless Tobacco ____Per Day

Other_____

HOW OFTEN DO YOU CONSUME ALCOHOL?

__1-3 Ounces Daily __More than 3 Ounces Daily
__Less than One Ounce Daily __No Alcoholic Beverages

Other_____

CAFEINE HISTORY

__Cups of Caffeinated Coffee Daily __No Caffeinated Beverages
__Ounces of Caffeinated Soda Daily

ALLERGIES

__NO KNOWN ALLERGIES
__Codeine __General Anesthesia __Penicillin
__Bug Bites __Hay Fever __Sulfa Drugs
__Dust and Pollen __Medication Allergies_____
__Food Allergies

Other_____

DESCRIBE PREVIOUS DENTAL TREATMENTS

__Bite Adjustment __Gum Surgery __Removable Dentures __TMJ Surgery
__Bite Splint __Oral (Not TMJ) Surgery __Root Canals __Widsom Teeth Extracted
__Crowns or Bridges __Orthodontics __Routine Dental Care
__Fractured Jaw __Teeth Extracted and Not Replaced

Other_____

WHAT MAKES YOUR PAIN WORSE?

__Alcohol __Driving __Opening Wide __Stress
__Bending Over __Exertion __Pressure __Talking
__Cold __Hot __Singing
__Chewing __Lying Down __Sitting

Other_____

WHAT REDUCES YOUR PAIN?

__Hot Compresses __Massage __Rest
__Cold Compresses __Medication __Sleep

Other_____

Example: If you have pain that is on average midway between "No Pain" at all and the "Most Pain" you have ever experienced, then you should place a mark midway on the line.

No Pain----------**I**----------**Most Pain**

PLEASE PLACE A MARK ON EACH OF THE LINES BELOW SHOWING YOUR PAIN LEVEL

PAIN NOW

NO PAIN_____**MOST INTENSE PAIN**

PAIN IN PAST

NO PAIN_____**MOST INTENSE PAIN**

PAIN WITH CHEWING

NO PAIN_____**MOST INTENSE PAIN**

PLEASE MARK THE APPROPRIATE RESPONSES RELATED TO ANY SLEEP PROBLEMS

__No Sleep Problems __Difficulty Returning to Sleep __Fatigued on Awakening
__Awakened by Pain __Teeth Grinding/Clenching __Frequent Awakenings
__Daytime Sleepiness __Not Due to Chief Complaint
__Difficulty falling asleep Due to Chief Complaint __Due to Chief Complaint
__Difficulty Falling Asleep NOT Due to Chief Complaint __None

Other_____

HAVE YOU HAD PREVIOUS HEADACHES DIAGNOSED?

__Cluster
__Migraine with Aura
__Migraine without Aura
__Tension-Type Headache
__Sinus
__Not been Diagnosed

Other_____

PLEASE CHECK THE APPROPRIATE RESPONSES RELATED TO ANY EAR PROBLEMS

__Drainage
__Hearing Loss
__Hypersensitive Hearing
__Itching
__No Problems
__Stuffiness
__Ringing in Ears
__Dizziness

Other_____

****PLEASE SKIP THIS NEXT SECTION IF YOU HAVE NOT BEEN INVOLVED IN AN AUTO ACCIDENT****

DESCRIBE YOUR ACCIDENT:

_____
_____

DATE OF ACCIDENT:_____

RESTRAINT

__Restrained by Deployed Airbag Only
__Restrained by Harness and Airbag
__Restrained by Seat Belt and Air Bag
__Restrained by Seat Belt Only
__Restrained by Shoulder Harness
__Unrestrained

YOUR LOCATION DURING THE ACCIDENT

__In the Driver's Seat
__In the Right Front Passengers Seat
__In the Center Front
__In the Middle Seat
__In the Back Left Seat
__In the Back Right Seat
__In the Center Back

TYPE OF VEHICLE

__Car __Truck __Van

PRIMARY IMPACT TO THE VEHICLE

__Front
__Front Left
__Front Right
__Left Door Panel
__Left Front Quarter
__Left Rear Quarter
__Right Door Panel
__Right Front Quarter
__Right Rear Quarter
__Rear
__Rear Left
__Rear Right

IMPACT WAS WITH

__A Stationary Object
__A Vehicle Moving from Left to Right
__A Vehicle Moving from Right to Left
__A Vehicle Moving Parallel to Yours

APPROXIMATE SPEED AT THE TIME OF IMPACT

__1 MPH
__5 MPH
__10 MPH
__15 MPH
__20 MPH
__25 MPH
__30 MPH
__40 MPH
__50 MPH
__60 MPH
__IN EXCESS OF 60 MPH

SECONDARY IMPACT

__Did Not Occur
__Was Due to a Vehicle Rollover
__Was to the Front of the Vehicle
__Was to the Rear of the Vehicle
__Was to the Left of the Vehicle
__Was to the Right of the Vehicle

LOCATION OF SUSTAINED TRAUMA

__No Direct Trauma to the Head or Face
__Direct Trauma to the Top of the Head
__Direct Trauma to the Forehead: __Left __Right __Bilateral
__Direct Trauma to the Back of the Head
__Direct Trauma to the Jaw: __Left __Right __Bilateral
__Direct Trauma to the Jaw Point: __Left __Right __Bilateral
__Direct Trauma Behind the Ear: __Left __Right __Bilateral
__Direct Trauma to the Ear: __Left __Right __Bilateral
__Direct Trauma to the Cheek: __Left __Right __Bilateral
__Direct Trauma to the Chin
__Direct Trauma to the Nose
__Direct Trauma to the Lips
__Fracture of a Tooth or Teeth
__Direct Trauma to the Philtrum Region

SYMPTOMS OF THE TMJ/FACIAL PAIN WERE FIRST NOTED

__The Day of the Impact
__The Next Day
__One Week Later
__One Month Later
__Six Months Later
__One Year or More Later

IS THE PATIENT PRESENTLY AT MMI

__Yes __No __Unknown

PRESENCE OF PARTIAL PERMANENT IMPAIRMENT

__None
__Joint Dysfunction: __%
__Fracture: __%
__Disc Displacement: __%
__Hypo-Mobility __%
__Surgical Intervention: __%

END OF ACCIDENT SECTION