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Physical Therapy & Wellness of Richmond

TMJ/TMD QUESTIONNAIRE

Patient Name: _____ Date: _____

Name of Dentist/Oral Surgeon/Orthodontist: _____

DENTAL HISTORY

Which side of your jaw is affected? _____Right _____Left _____Both

Have you had or do you currently have any of the following:

Jaw Clicking/Popping	_____YES	_____NO	
Jaw Locking	_____YES	_____NO	
Braces	_____YES	_____NO	If yes, dates: _____
Splint Therapy	_____YES	_____NO	If yes, dates: _____
Oral Surgery	_____YES	_____NO	If yes, dates: _____
Headaches	_____YES	_____NO	If yes, _____x/week
Tinnitus (ringing in ears)	_____YES	_____NO	
Hearing Loss	_____YES	_____NO	
Blurred/Double Vision	_____YES	_____NO	
Pain with chewing	_____YES	_____NO	
Pain with talking	_____YES	_____NO	
Pain with yawning	_____YES	_____NO	

Do you currently do any of the following:

Clench/Grind Teeth	_____YES	_____NO
Chew fingernails/pens	_____YES	_____NO
Chew gum	_____YES	_____NO

Are you currently eating a soft food diet? _____YES _____NO

Does your tongue rest at the roof of your mouth when not eating or talking? _____YES _____NO