IRELAND MANUAL PHYSIOTHERAPY

Name:______________________________

DOB:______________________________

Confidential Health History Form: TMJ Questionnaire

TMJ Questions

Do you have any pain/discomfort in your:

☐Jaw ☐Face ☐Head ☐Neck ☐Arms ☐Teeth ☐Ears

Please elaborate:

Do you have any:

☐Pins or needles
☐Areas of numbness
☐Other unusual feelings or sensations
☐All of the aforementioned coming on at the same time
☐Constant pain

Over the past few days, has the pain been getting:

☐Better
☐Worse
☐Remains the same

Do any of the following cause pain or discomfort?

☐Opening the mouth
☐Closing the mouth
☐Eating/chewing
☐Yawning
☐Swallowing
☐Speaking
☐Shouting
☐Other – Please describe:

Do you experience any of the following:

☐An uncomfortable or unusual bite
☐Teeth griding
☐Holding your teeth tightly together
☐Jaw clicking
☐Noises in your jaw joint
☐Jaw getting stuck
☐Jaw locking
☐Jaw going “out”

Do you do any of the following:

☐Smoke a pipe
☐Use a cigarette holder/vape
☐Chew gum
☐Bite your nails, etc.
☐Rest/sleep with your chin on your hand
☐Breathe mostly through your mouth

Do you experience any of the following:

☐Pain that keeps you awake at night
☐Pain that feels better after a night’s rest
☐Jaw stiffness in the morning
☐Pain that varies throughout the day
☐Pain that increases steadily as the day goes on
☐Pain that depends on the activity you are doing
☐Injury to your jaw
☐Injury to your head
☐Injury to your neck

Other Care Providers

Have you recently been seen by any of the following for your concern? If yes, can you indicate who?

☐Dentist
☐Periodontist
☐Orthodontist
☐Endodontist

Past Jaw Treatment

Have you had any of the following?

☐Splint occlusal therapy
☐Botox, or similar
☐Physiotherapy
☐Massage therapy
☐Osteopathy
☐Pain Injections

Dental/Systemic Screening

Have you or do you have any of the following?

Missing teeth ☐Changes in your voice ☐Feeling dizzy or faint ☐Feelings of nausea or episodes of vomiting

Client Signature: Date:

Name:______________________________
DOB:______________________________

Confidential Health History Form

[Type here]