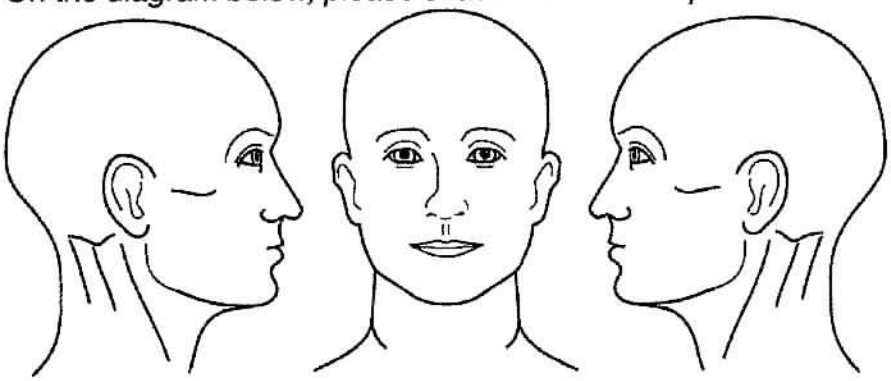
FILL THIS NEXT 4 PAGE INTAKE FORM OUT ONLY IF **TMJ** SYMPTOMS ARE OF ISSUE

PATIENT NAME:_____DATE:_____

On the diagram below, please shade the areas of pain:



Date your symptoms began:_____
What symptoms are you experiencing? *clicking R L popping R L pain R L*

What caused it? (circle) *Trauma or Unknown (insidious)*

What makes it feel better?_____
What makes it feel worse?_____
What treatments have you received?_____
_____
Have you been prescribed a mouth guard, splint, or appliance? *Yes No*
Do you still wear it? *Yes No*
When are symptoms worse? *upon awakening later in day no daily pattern*
*other*_____
What do the symptoms keep you from doing?_____
Is pain: *Achy Pressure Dull Sharp Throbbing Burning Tightness other*_____
Does the pain:
Wake you up at night? *Yes No*
Increase when you lie down? *Yes No*
Increase when you end forward? *Yes No*
Increase when you drink hot or cold beverages? *Yes No*
Circle the number below to indicate your present level of pain:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)
Is the pain always present? *Yes No*
How often do you have it? *10% 20% 30% 40% 50%60% 70% 80% 90% 100% of day*
Describe any other symptoms that you associate with the problem:
_____
_____
_____

Have you had:
yes no Neck or head surgery?
yes no Whiplash or trauma to your head or neck?
yes no Shingles on your head or neck?
Do you CURRENTLY have:
yes no A fever?
yes no Nasal congestion or stuffiness?
yes no Movement difficulties of your facial muscles, eyes, mouth or tongue?
yes no Numbness or tingling of face?
yes no Numbness or tingling in hands? R or L
yes no Problems with your teeth?
yes no Swelling over your jaw joint or in your mouth or throat?
yes no A certain spot that triggers your pain? Where?_____
yes no Recurrent swelling or tenderness of joints other than in your jaw joint?
yes no Morning stiffness in your body, other than with your jaw?
yes no Muscle tenderness in your body other than in your head or neck) for more than 50% of the time? Where?_____
yes no Inability to open mouth smoothly? R or L

Is your problem worse:
yes no When swallowing or turning your head?
yes no After reading or straining your eyes?

yes no Do your jaw joints make noise upon __opening or__closing? R or L
clicking popping grinding

yes no Have you noticed any clicking, popping or other noises (with or without pain) in the temporomandibular joints (TMJ) occurring with mouth movement?

yes no Have you ever been unable to open your mouth wide?
Explain:_____
yes no Have you ever been unable to close your mouth?
Explain:_____

yes no Do you sleep well at night?
yes no Does your partner tell you that you grind your teeth at night?

How often are you tense, aggravated or frustrated during a usual day?
always half the day seldom never
How often do you feel depressed during a usual day?
always half the day seldom never

yes no Do you have suicidal thoughts or thoughts of hurting others?
yes no Do you play a wind instrument or/and sing more than 5 hours per week?
yes no Are you aware of clenching or grinding your teeth when sleeping?
yes no Are you aware of clenching or grinding your teeth while driving?

yes no Are you aware of clenching or grinding your teeth when using computer?
yes no Are you aware of clenching or grinding your teeth at other times?

What % of day are you teeth touching?_____%

yes no Are you aware of oral habits such as: (circle all that apply)
chewing your cheeks chewing objects biting your mails/cuticles
tapping your teeth together thrusting out your jaw other habits not aware

What treatment do you think is need for your problem?_____

Is there anything else you think we should know about your problem?
_____

yes no Have you ever been treated for this before? When?_____Duration:_____
By whom?_____What treatment?_____
Outcome?_____

yes no Have you noticed any sense of an altered bite, altered jaw posture or altered jaw function during chewing, speech or other mouth movement?

yes no Have you noticed any symptoms associated with your ears? (circle)
diminished hearing loss ringing, buzzing, hissing roaring sounds
sense of pressure pain without infection stuffiness or clogged feeling

yes no Have you noticed any symptoms associated with your eyes?
eye pain, above, below, or behind eyes bloodshot eyes blurred vision
bulging eyes pressure behind eyes watering of eyes drooping of eyelids

yes no Have you noticed any symptoms associated with your throat? (circle)
swallowing difficulties tightness sore throat voice fluctuations
laryngitis frequent coughing/clearing throat tongue pain
feeling of foreign object in throat excess salivation pain in hard palate

yes no Have you noticed that nay of the symptoms in the head, neck and shoulder region that you are experiencing are increased following speech, chewing, yawning, etc.?

yes no Have you noticed any tendency to clench your teeth?
yes no Are your teeth sensitive to hot or cold? (circle which one)
yes no Do you have tooth pain? Which one/s?_____
yes no Do you have a loose tooth? Which one/s?_____
yes no Do you have dizziness or balance problems or vertigo?
yes no Do you breath with an open mouth?
yes no Do you have frequent headaches? How often?_____
yes no Do you have cheek pain? R or L

yes no Do you have low back pain? R or L
yes no Do you have neck pain? R or L

Do you have a PAST HISTORY of:

yes	no	Jaw pain?	R or L
yes	no	Jaw joint noises?	R or L
yes	no	Limited opening/movement?	R or L
yes	no	Jaw sticking/locking/dislocation	R or L
yes	no	Stiff/tight or tired jaw?	R or L
yes	no	Painful opening/closing?	R or L
yes	no	Facial pain/tightness?	R or L
yes	no	Headaches?	
yes	no	Ear pain?	R or L
yes	no	Stuffiness in ears ?	R or L
yes	no	tinnitus/ringing in ears?	R or L
yes	no	Vertigo/dizziness	
yes	no	Difficulty swallowing	
yes	no	Neck aches/ history of whiplash	
yes	no	Decreased range of motion with neck	R or L
yes	no	Low back pain, chronic	R or L
yes	no	Recent changes in bite	R or L
yes	no	Recent injury to head, neck, or jaw	
yes	no	Eye pain	
yes	no	Chronic fatigue	
yes	no	Disequilibrium/dis-co-ordination	
yes	no	Mental confusion	
yes	no	Irritability	
yes	no	Bell's Palsy	R or L
yes	no	Trigeminal Neuralgia/Tic douloureux	R or L

To the best of my knowledge the above information is correct and I give permission for a written report to be sent to my referring and treating doctors and dentists if needed.

*Patient signature:*_____*Date:*_____

INFORMED CONSENT:
A cervical manual chiropractic adjustment can cause bodily harm. I have been informed verbally and now in writing of this risk.

*Patient signature:*_____*Date:*_____

STRESS SURVEY

Many changes or events in your life cause stress and can make you more susceptible to illness, pain, and the perception and interpretation of pain and symptoms, including TMJ symptoms. This scale can help you recognize when you are under unusual stress.

To determine your life stress score add up the number of stress units for each event that you have experienced during the last year. A score of 150 points means a 50% chance of developing an illness. A score 300 means a 90% chance.

100	Death of a spouse
73	Divorce
63	Marital separation
63	Jail term
63	Death of close family member
53	Personal injury or illness
50	Marriage
47	Fired from work
45	Marital reconciliation
45	Retirement
44	Change in health of family member
40	Pregnancy
39	Sex difficulties
39	Gain of new family member
39	Business readjustment
38	Change in financial state
37	Death of close friend
36	Change to different line of work
35	Change in #of arguments w/ spouse
31	Mortgage of $100,000*
30	Foreclosure of mortgage or loam
29	Change in responsibilities at work

____ TOTAL SCORE