**TMJ Health Questionnaire**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Complaint\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Symptoms**

Do you get headaches in right or left temple areas? Y N Do you get headaches in the front or back

of your head? Y N

Do you clench your teeth during the day? Y N

Do you clench your teeth during the night? Y N Do you grind your teeth when asleep? Y N Do you wear a mouthguard? Y N

When are your symptoms worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anything make you feel better?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you take medication for pain relief?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever been involved in any serious accidents, such as a car accident? Y N

Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel or hear a ‘clicking’, ‘popping’ or

‘cracking’ noise from either jaw joint? Y N

Has your jaw ever locked when you were

unable to open or close? Y N

Do you have difficulty opening wide or yawning? Y N

Have you ever had pain in either jaw joint? Y N

Does your jaw ache when you open wide? Y N

**Eye Symptoms**

Do you wear glasses or contacts? Y N

Are there times when your eyesight blurs? Y N

Do you get pain in, around or behind either eye? Y N

**Ear Symptoms**

Do you have any pain in your ears? Y N

Do you suffer from any loss of hearing? Y N

Do you hear ringing, buzzing, or hissing

sounds in either ear? Y N

Do you get headaches? Y N

Do you get migraine headaches? Y N

Do you frequently have neck aches

or stiff neck muscles? Y N

Are your jaws tired when you awaken? Y N

Are your teeth sore when you awaken? Y N

What medication(s), if any, are you taking?

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**Trauma or Accidents**

Have you ever had a severe blow to the

head or jaw? Y N

Any whiplash neck injuries? Y N

Any neck surgery? Y N

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**Jaw Joint Symptoms**

Does your jaw feel tired after a big meal? Y N

Are there any foods you avoid eating? Y N

Do you ever get dizzy? Y N

Do you ever feel faint? Y N  
Do you ever feel nauseated (sick)? Y N

Is there a family history of jaw joint (TMJ)

Problems or headaches? Y N

**Breathing**

Do you have allergies? Y N

Do you have sinus problems? Y N

Do you snore at night? Y N Have you been diagnosed with Sleep Apnea? Y N Have you had a sleep study done at a Sleep

Clinic (hospital)? Y N

**Informed Consent for TMJ Therapy**

TMJ therapy, (including intraoral treatment), like all forms of healthcare, while offering considerable benefit may also include concerns of muscle soreness following a treatment.

I acknowledge that TMJ therapy is not a substitute for medical care, medical exam or diagnosis and that I should see a qualified medical professional for any mental or physical ailment of which I am aware.

I affirm that I have stated all known medical conditions and answered all questions on my health form honestly. I agree to keep the massage therapist updated as to any changes in my medical profile and understand there shall be no liability on the massage therapist if I fail to do so.

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_