Meir N Keller DDS
Cranio Facial Pain & Disorders

TMJ
EVALUATION FORM

NAME:_____DATE:_____AGE:_____

IN YOUR OWN WORDS PLEASE EXPLAIN WHY YOU ARE HERE: _____

_____

DATE PROBLEM BEGAN:_____ AGE PROBLEM BEGAN:_____

PREVIOUS FACIAL INJURY? ☐ NO ☐ YES WHEN WAS THE INJURY?_____

IF YES, PLEASE GIVE DETAILS OF THE INJURY._____

_____

PLEASE CHECK WHETHER YOU HAVE HAD ANY OF THE FOLLOWING:

			RESULTS: Good	Fair	Poor
☐	ORTHODONTICS	WHEN?_____	☐	☐	☐
☐	OCCLUSAL ADJUSTMENT	WHEN?_____	☐	☐	☐
☐	PHYSICAL THERAPY	WHEN?_____	☐	☐	☐
☐	TMJ SPLINT	WHEN?_____	☐	☐	☐
☐	TMJ ARTHROSCOPIC SURGERY	WHEN?_____	☐	☐	☐
☐	TMJ OPEN JOINT SURGERY	WHEN?_____	☐	☐	☐
☐	TMJ PROSTHETIC REPLACEMENT	WHEN?_____	☐	☐	☐

MEDICATIONS TAKEN IN THE PAST FOR TMJ:_____

_____

CURRENT MEDICATIONS FOR TMJ:_____

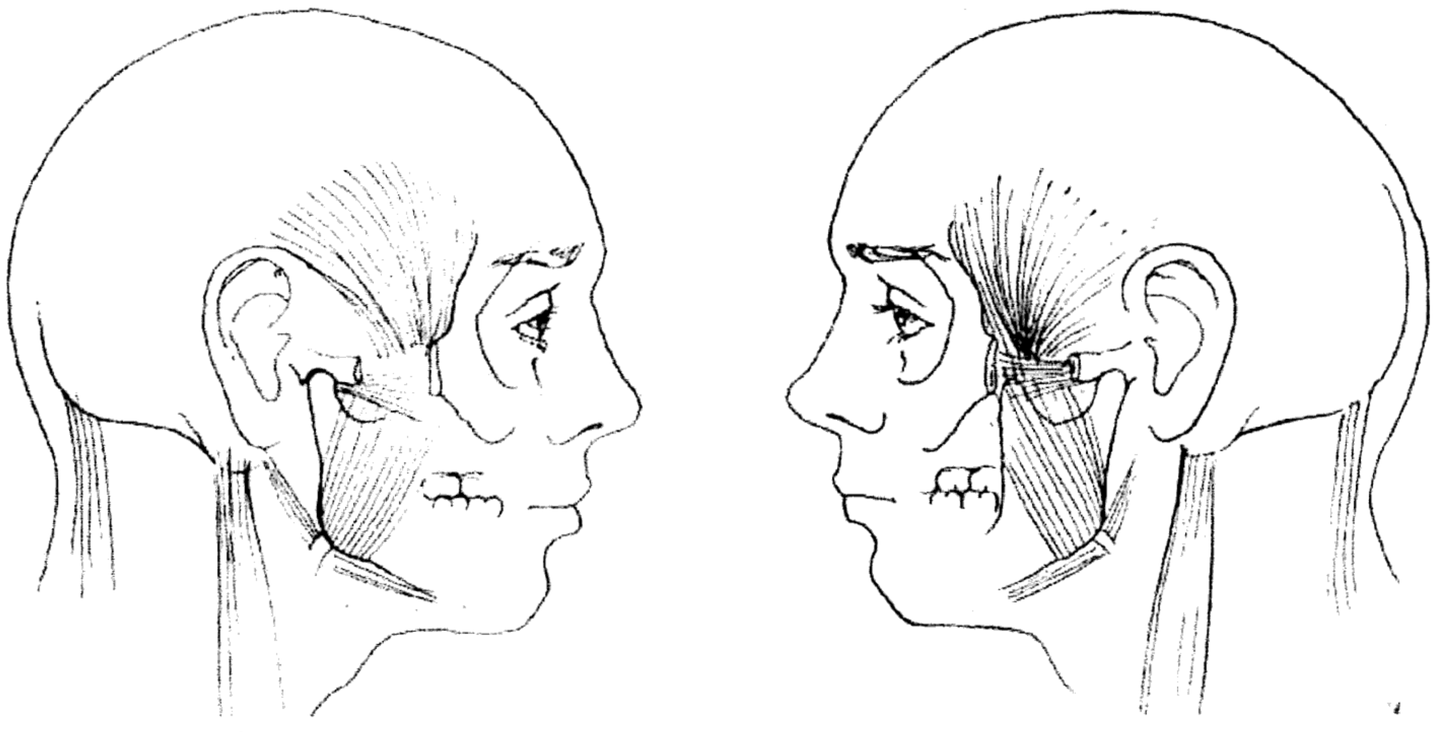
_____

INDICATE ON THE FOLLOWING SCALE HOW SEVERE YOUR PAIN IS THE MAJORITY OF THE TIME.

←----------→

0 NO PAIN **1 2 3 4 5 6 7 8 9 10** SEVERE PAIN

PLEASE INDICATE WHERE YOU ARE HAVING PAIN ON THE DIAGRAM BELOW



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drkellerdds.com

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IS THE PAIN CONSTANT OR INTERMITTENT? (CIRCLE ONE)

DOES IT HURT TO MOVE YOUR JAW? ☐ YES ☐ NO
TO CHEW? ☐ YES ☐ NO

DOES THE PAIN/PROBLEM LIMIT YOUR FUNCTION? ☐ YES ☐ NO
IF SO, HOW?_____

WHEN IS THE PAIN WORSE? MORNING AFTERNOON EVENING (CIRCLE ONE)
OTHER TIME:_____

DOES ANYTHING YOU DO MAKE THE PAIN WORSE?_____
WHAT?_____

DOES ANYTHING YOU DO MAKE THE PAIN BETTER?_____
WHAT?_____

WHAT OTHER DOCTORS OR HEALTH CARE ASSOCIATES HAVE YOU SEEN REGARDING THIS PAIN/PROBLEM?_
_____

DOES YOUR JAW EVER LOCK OPEN?_____ CLOSED?_____
HOW HAS THIS BEEN TREATED?_____
CAN YOU DO ANYTHING TO PREVENT OR TREAT THIS?_____

DO YOU GRIND OR GRIT YOUR TEETH? ☐ YES ☐ NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

SINUS PROBLEMS_____	HEARING CHANGES_____	STRESSFUL JOB_____
SENSITIVE TEETH_____	RINGING IN EARS_____	MARITAL PROBLEMS_____
PERIODONTAL DISEASE_____	DIZZINESS_____	TROUBLE SLEEPING_____
HEADACHES_____	SHOULDER PAIN_____	ULCERS_____
MIGRAINES_____	ARTHRITIS_____	NERVOUS STOMACH_____
NECK ACHE_____	SKIN DISEASES_____	ALLERGIES_____
EAR ACHE_____	DEPRESSION_____	to WHAT?_____

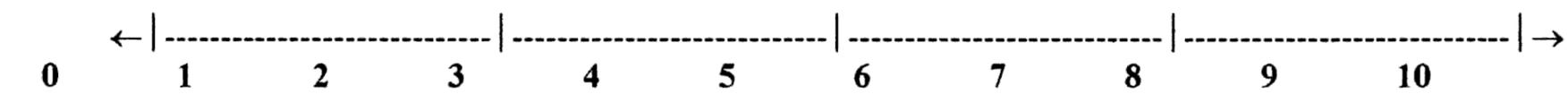
LIST OTHER MEDICAL PROBLEMS:_____

_____

_____

_____

THE PAIN IS HAVING THIS EFFECT ON MY LIFE.



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