Patient Questionnaire for Temporomandibular Disorders Treatment Progress

1. How are you feeling today on a scale of 1 to 10?
   (1 = No Pain 10 = Worst Possible) Circle your choice.

   1 2 3 4 5 6 7 8 9 10

2. How have you felt since your last appointment on a scale of 1 to 10?
   (1 = No Pain 10 = Worst Possible) Circle your choice.

   1 2 3 4 5 6 7 8 9 10

3. What symptoms (if any) are better?

   _____
   _____
   _____

4. What symptoms (if any) are the same?

   _____
   _____
   _____

5. What symptoms (if any) are worse?

   _____
   _____
   _____

6. Do you feel our therapy is helping you? Please circle. YES NO

7. If you are receiving physical therapy at another facility, do you feel that the therapy is helping you? Please circle. YES NO

8. On average I have worn my appliance(s) _____ hours per day.

Ella Walsh
Patient Name

_____
Date

_____
Patient Signature

_____
Reviewed By

Office Use

ROM

Interincisal Opening _____mm
Overbite _____mm
Overjet _____mm

Lateral Excursion RT _____mm
Lateral Excursion LT _____mm

SIGNS

Deviation/Deflection Opening/Closing Right/Left
Clicking/Crepitis/Pain Opening/Closing Right/Left

TREATMENT

Transcranials With/Without Appliance/Initial
JVA With/Without Appliance/Initial
Splint Insert/Reline/Adjust

Panorex/Ceph/Models/Muscle Palpation/TMJ Questionnaire
Medical Changes_____
Next Visit_____

Version: TMDOU

TMD Orthotic Use

OFFICE USE
Patient ID:

NAME: _____ CURRENT DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

Orthotic Use

☐ Yes
☐ No — Do you easily sleep with the orthotic?

☐ Yes
☐ No — Any retention problems?

Tooth tenderness
- ☐ Same
- ☐ Yes
- ☐ No
- ☐ sometimes
- ☐ _____

Changes in tooth contact
- ☐ slight tenderness
- ☐ No
- ☐ Not Sure
- ☐ yes on left side molars
- ☐ better bite (occlusion)
- ☐ sometimes
- ☐ a little change
- ☐ yes
- ☐ no
- ☐ No changes in tooth contact
- ☐ Changes in tooth contact
- ☐ _____

Temporomandibular joint tenderness
- ☐ Yes
- ☐ No
- ☐ Slight tenderness
- ☐ Moderate tenderness
- ☐ Severe tenderness
- ☐ TM joint has stopped catching when using device
- ☐ _____

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____