

TMD/Migraine Therapy Questionnaire

Patient Name: _____ Date: _____

Age: _____ Phone: _____

Please enter yes or no and briefly describe symptoms:

1. Do you have difficulty, pain or both on opening wide or when you chew?
2. Are you aware of noises in the jaw joints?
3. Do your jaws feel stiff, tight or tired after eating?
4. Do you have any kind of sounds, feelings or discomfort in your ears?
5. Do you have frequent neck aches?
6. Do you have headaches/migraines? Describe.
7. Are you aware of changes in your bite?
8. Have you had Orthodontic treatment?
9. Have you ever had a splint?
10. Do you grind or clench your teeth?
11. Do you have shoulder pain?
12. Is stress/anxiety a problem?
13. How much time do you spend making computer entries daily?
14. Have you ever had a car accident or trauma to your head? When?