



PHYSICAL THERAPY SERVICES OF ROCHESTER, P.C.

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(585) 427-7190 FAX: (585) 427-2287

Craniomandibular / TMJ History Questionnaire

Name: _____

Date: _____

Please answer these questions to the best of your ability. Please give necessary details for **yes** answers. I realize that this form is long, but when it is filled out carefully, it allows us to devote more time to your specific problem, rather than asking you related questions during your visit. *Thank you. Susan Hawley, PT*

1) Describe your problem or the reason why you are seeing me. _____

2) How & when did this start? _____

3) Is it getting better? worse? staying the same?

4) Have you had this problem before? Yes No When? _____

If yes, what happened then? _____

5) Do your symptoms come and go? Or are they constant?

6) What, if anything, eases your pain? _____

7) What makes your pain worse? _____

8) Do stressful situations increase your symptoms? Yes No

9) Do you have any nervous habits? (e.g. nail biting or pencil chewing) _____

10) Do you have trouble sleeping because of your pain? Yes No

11) Do you sleep on your? stomach back side

12) Do you use a support for your neck when you sleep? Yes No

13) Do you have any numbness? Yes No

If so, where? _____

14) How do you feel in the morning? Fine Stiff and sore In pain

15) How do you feel as the day goes on? Better Worse Same

JAW SYMPTOMS**Yes****No**

1) Do you have joint noises with movement of your jaw?		
2) Do you have pain associated with the noises?		
3) Are your jaw muscles tired or painful during the day?		
4) Do you have pain when you yawn?		
5) Has your jaw ever locked open or closed?		

TOOTH/MOUTH SYMPTOMS**Yes****No**

1) Do you grind or clench your teeth while asleep or awake?		
2) Do you feel like your bite is off?		
3) Do you feel like your teeth are loose or moving?		
4) Do you have a tendency to bite your cheeks, lips or tongue?		
5) Do you have difficulties swallowing?		
6) Do you have dried or chapped lips?		
7) Do you have soreness in your throat or do you clear it a lot?		
8) Do you have trouble breathing through your nose?		

EAR/EYE SYMPTOMS**Yes****No**

1) Do you have pain on the side of your head? (temples)		
2) Do you have pain in or around your eyes?		
3) Do you have pain in or around your ears?		
4) Have you had any recent change in your hearing or vision?		
5) Do you have ringing in your ears?		
6) Do you experience unexplained dizziness?		
7) Do you experience fullness or pressure in your ears?		

HEAD/NECK/SHOULDER SYMPTOMS**Yes****No**

1) Have you had head, neck or back problems? When?		
2) Do you presently have neck or shoulder pain? Neck: <input type="checkbox"/> L <input type="checkbox"/> R Shoulder: <input type="checkbox"/> L <input type="checkbox"/> R		
3) Do you have headaches? Where? Forehead: <input type="checkbox"/> L <input type="checkbox"/> R Facial: <input type="checkbox"/> L <input type="checkbox"/> R Back of head: <input type="checkbox"/> L <input type="checkbox"/> R Temples: <input type="checkbox"/> L <input type="checkbox"/> R Top of head: <input type="checkbox"/> L <input type="checkbox"/> R Varies: <input type="checkbox"/> L <input type="checkbox"/> R		
4) Do you have pain that extends into your arms? Where? <input type="checkbox"/> L <input type="checkbox"/> R		
5) Do you have weakness or tingling in your arms?		
6) Is the pain of a burning nature?		
7) Is the pain <input type="checkbox"/> dull or <input type="checkbox"/> sharp or <input type="checkbox"/> aching?		

DENTAL HISTORY

1) What X-Rays or other diagnostic tests have you had? _____

2) Have you had any major dental work/surgery or orthodontic treatment done? Yes No

If yes, what and when? _____

3) Do you wear a bridge or denture? Yes No If yes, Partial Full

4) Have you had a bite adjustment to improve your bite or to help your pain? Yes No When? _____

5) Do you have any teeth missing? Yes No

6) Do you wear a mouth appliance? Yes No

If yes, are you wearing it now? Yes No Since when? _____

How often do you wear it? _____ Does it help or aggravate your symptoms?

Do you feel it is balanced? Yes No

Do you feel the appliance is too thick too thin just right?

7) When do you see your dentist again? _____

8) What other treatment have you had for this problem? _____

Thank you for taking the time to fill out this form. If you have any need to change or cancel your appointment, please call the office at (585) 427-7190 as soon as possible.