JULIAN CENTER
for comprehensive dentistry
5012 Dorsey Hall Dr. Suite 205
Ellicott City, MD 21042
www.JulianDentist.com
(410)964-3118

TMJ DISORDER, FACIAL PAIN, HEADACHE AND MIGRAINE QUESTIONNAIRE

Name:	Date:	Age:	Sex:
Signature:		Birthdate:	

1.	Do you have pain in the face, neck or shoulder?	Yes	No
2.	Do you experience headaches or migraines?	Yes	No
3.	Do you have recurring tooth pain or sensitivity?	Yes	No
4.	Do you have ringing, fullness or pain in your ears?	Yes	No
5.	Do you have difficulty opening your mouth or does your jaw get “stuck” or locked?	Yes	No
6.	Do you have any clicking or popping in your jaw?	Yes	No
7.	Does your jaw joint create any noise, such as grating?	Yes	No
8.	Do you have difficulty or pain with chewing, talking or yawning?	Yes	No
9.	Do you grind or clench your teeth? (during the day or night)	Yes	No
10.	Do you have any history of arthritis?	Yes	No
11.	Do your jaw muscles ever get tired, or ache?	Yes	No
12.	Do you have difficulty swallowing pills?	Yes	No
13.	Do you have any history of trauma to your head or jaw?	Yes	No
14.	Have you been in a motor vehicle accident?	Yes	No
15.	Have you had any previous treatment for your jaw joint (TMJ disorders)?	Yes	No
16.	Do you constantly clear your throat?	Yes	No
17.	Do you snore?	Yes	No
18.	Do you have difficulty sleeping through the night?	Yes	No
19.	Do you feel anxious or on edge?	Yes	No
20.	Do you have a history of restless leg syndrome?	Yes	No
21.	Are you able to breathe through both sides of your nose?	Yes	No
22.	Did a Doctor ever tell you your symptoms are “just all in your head”?	Yes	No
23.	Do you experience any acid reflux?	Yes	No