# Welcome to Waterfront Family Dental

**Thank you for choosing Waterfront Family Dental for your TMJ evaluation.**

**We understand that jaw pain, head pain, facial pain, ear symptoms, neck discomfort, and sleep-related concerns can affect nearly every aspect of your daily life. These symptoms can make it difficult to eat, speak, work, sleep, and enjoy the activities you love.**

**This assessment is your opportunity to tell us your story before your appointment. The more we understand your symptoms, when they occur, and how they impact your daily life, the better we can evaluate your condition and develop a treatment plan tailored to your individual needs.**

**There are no right or wrong answers. Simply share your experience as honestly and completely as you can. Your responses will help us understand what you're going through and allow us to provide the most comprehensive care possible.**

# Tell Us About Your Head Pain

**Many people with jaw disorders experience pain or pressure in their head, face, or temples. These symptoms may or may not feel like a traditional headache. Please tell us about your experience.**

## Do you experience head pain?

☐ Yes

☐ No

☐ Occasionally

## How would you describe your head pain?

*(Check all that apply.)*

☐ Dull or aching

☐ Pressure or tightness

☐ Throbbing or pulsating

☐ Sharp or stabbing

☐ Burning

☐ Squeezing or band-like

☐ Tender to touch

☐ Heavy feeling

☐ Comes and goes

☐ Constant

## Where do you usually feel your head pain?

*(Check all that apply.)*

☐ Forehead

☐ Temples

☐ Behind the eyes

☐ Top of the head

☐ Back of the head

☐ Base of the skull

☐ Entire head

☐ Face

☐ Other

## Which side is affected?

☐ Right

☐ Left

☐ Both sides

☐ Varies

## How often do you experience headaches?

☐ Every day

☐ Several times each week

☐ Once a week

☐ Several times a month

☐ Occasionally

## Approximately how long do your headaches last?

☐ Less than 30 minutes

☐ 30 minutes–2 hours

☐ 2–6 hours

☐ Most of the day

☐ All day

☐ More than one day

## When do they usually occur?

☐ Upon waking

☐ Mid-morning

☐ Afternoon

☐ Evening

☐ During the night

☐ Randomly

## What activities seem to make your headaches worse?

☐ Chewing

☐ Talking for long periods

☐ Stress

☐ Computer work

☐ Reading

☐ Driving

☐ Exercise

☐ Bright lights

☐ Loud noises

## What helps relieve your headaches?

☐ Rest

☐ Ice

☐ Heat

☐ Massage

☐ Medication

☐ Sleep

☐ Stretching

☐ Nothing seems to help

☐ Other

## Do your headaches ever include any of the following?

☐ Nausea

☐ Sensitivity to light

☐ Sensitivity to sound

☐ Dizziness

☐ Blurred vision

☐ Ringing in your ears

☐ None of the above

## Do your headaches ever wake you from sleep?

☐ Yes

☐ No

### Have your headaches changed over time?

☐ They are becoming more frequent.

☐ They are becoming more severe.

☐ They have stayed about the same.

☐ They have improved.

### Please Rate Your Headaches/Headpain

**0 1 2 3 4 5 6 7 8 9 10**

### Tell Us About Your Jaw

Your jaw joint and the muscles that control it are used hundreds of times every day for eating, talking, yawning, and smiling. These questions help us understand how your jaw symptoms affect your daily life.

### Do you experience jaw pain?

☐ Yes

☐ No

☐ Occasionally

### Which side of your jaw is affected?

☐ Right

☐ Left

☐ Both

☐ It varies

### Where do you feel your jaw pain?

*(Check all that apply.)*

☐ In front of the ear

☐ Jaw joint

☐ Cheek

☐ Lower jaw

☐ Upper jaw

☐ Temple

☐ Under the jaw

☐ Other

## How would you describe your jaw pain?

*(Check all that apply.)*

☐ Dull or aching

☐ Sharp or stabbing

☐ Throbbing

☐ Burning

☐ Pressure or tightness

☐ Soreness

☐ Tender to touch

☐ Cramping

☐ Fatigue or tiredness

☐ Comes and goes

☐ Constant

☐ Other

## When do you notice your jaw pain?

*(Check all that apply.)*

☐ Upon waking

☐ While eating

☐ After eating

☐ Talking for long periods

☐ Yawning

☐ During stressful situations

☐ At the end of the day

☐ Randomly

## What activities make your jaw pain worse?

*(Check all that apply.)*

☐ Chewing

☐ Opening wide

☐ Talking

☐ Yawning

☐ Clenching

☐ Grinding

☐ Stress

☐ Singing

☐ Exercising

☐ Other

## What helps relieve your jaw pain?

*(Check all that apply.)*

☐ Rest

☐ Heat

☐ Ice

☐ Massage

☐ Stretching

☐ Medication

☐ Soft foods

☐ Nightguard

☐ Nothing seems to help

☐ Other

## Have you noticed any of the following?

☐ Clicking

☐ Popping

☐ Grinding noises

☐ Locking open

☐ Locking closed

☐ Jaw catches before opening

☐ Jaw feels stuck

☐ Jaw shifts to one side

☐ Difficulty opening wide

☐ Pain with chewing

☐ Jaw fatigue

☐ Bite feels different

☐ None of the above

## Does your jaw ever lock?

☐ No

☐ Yes, occasionally

☐ Yes, frequently

If yes:

☐ Open

☐ Closed

☐ Both

## Approximately how wide can you comfortably open your mouth?

☐ Less than two fingers

☐ Two fingers

☐ Three fingers

☐ More than three fingers

☐ I'm not sure

## How does your jaw pain affect your daily life?

*(Check all that apply.)*

☐ I avoid certain foods.

☐ I cut food into smaller pieces.

☐ I chew on one side only.

☐ Talking for long periods causes discomfort.

☐ I avoid yawning because it hurts.

☐ I have difficulty enjoying meals.

☐ My jaw pain affects my sleep.

☐ My jaw pain affects my work.

☐ My jaw pain affects my mood.

## Please Rate Your Jaw Discomfort

**0 1 2 3 4 5 6 7 8 9 10**

## Tell Us About Your Ear Symptoms

**The jaw joint is located just in front of your ears, and problems with the jaw muscles and joints can sometimes cause symptoms that feel like an ear problem. These questions help us better understand your symptoms.**

## Do you experience ear symptoms?

☐ Yes

☐ No

☐ Occasionally

## Which ear is affected?

☐ Right

☐ Left

☐ Both

☐ It varies

## Which ear symptom bothers you the most?

*(Choose one.)*

☐ Ear pain

☐ Ear pressure or fullness

☐ Ringing in my ears (tinnitus)

☐ Popping or crackling

☐ Muffled hearing

☐ Dizziness or balance problems

☐ Sensitivity to sound

☐ Other

## Which ear symptoms do you experience?

*(Check all that apply.)*

☐ Ear pain

☐ Ear pressure or fullness

☐ Ringing in my ears (tinnitus)

☐ Popping or crackling

☐ Muffled hearing

☐ Feeling like my ears need to pop

☐ Itching inside the ear

☐ Dizziness

☐ Vertigo (room spinning)

☐ Balance problems

☐ Sensitivity to loud sounds

☐ Feeling of fluid in the ear

## When do you notice your ear symptoms?

*(Check all that apply.)*

☐ Upon waking

☐ While chewing

☐ While talking

☐ During jaw movement

☐ During stressful situations

☐ At the end of the day

☐ Randomly

## What seems to make your ear symptoms worse?

*(Check all that apply.)*

☐ Chewing

☐ Opening my mouth wide

☐ Clenching my teeth

☐ Grinding my teeth

☐ Stress

☐ Yawning

☐ Eating hard foods

☐ Loud noises

☐ Other

## What helps relieve your ear symptoms?

*(Check all that apply.)*

☐ Rest

☐ Heat

☐ Ice

☐ Massage

☐ Medication

☐ Soft foods

☐ Relaxing my jaw

☐ Nothing seems to help

☐ Other

## Have you been evaluated by another healthcare provider for your ear symptoms?

☐ No

☐ Primary Care Provider

☐ Ear, Nose & Throat (ENT) Specialist

☐ Audiologist

☐ Urgent Care

☐ Emergency Department

## If yes, what were you told?

☐ My ears were normal.

☐ I had an ear infection.

☐ I had fluid in my ears.

☐ Hearing loss was found.

☐ They couldn't find a cause.

☐ Other

## Do your ear symptoms change when you move your jaw?

☐ They get worse.

☐ They get better.

☐ They stay the same.

☐ I'm not sure.

## Please Rate Your Ear Discomfort

**0 1 2 3 4 5 6 7 8 9 10**

## Tell Us About Your Neck Discomfort

**The muscles of your jaw, neck, and shoulders work together every day. Tension or dysfunction in one area can often affect the others. These questions will help us better understand how your neck symptoms may relate to your jaw condition.**

## Do you experience neck discomfort?

☐ Yes

☐ No

☐ Occasionally

## Which side of your neck is affected?

☐ Right

☐ Left

☐ Both

☐ It varies

## Where do you feel your neck discomfort?

*(Check all that apply.)*

☐ Front of my neck

☐ Side of my neck

☐ Back of my neck

☐ Base of my skull

☐ Upper shoulders

☐ Between my shoulder blades

☐ Collarbone area

## How would you describe your neck discomfort?

*(Check all that apply.)*

☐ Dull or aching

☐ Sharp or stabbing

☐ Tightness

☐ Stiffness

☐ Burning

☐ Throbbing

☐ Muscle soreness

☐ Tender to touch

☐ Cramping

☐ Fatigue or heaviness

☐ Comes and goes

☐ Constant

## When do you notice your neck discomfort?

*(Check all that apply.)*

☐ Upon waking

☐ After working at a computer

☐ Driving

☐ Reading

☐ Looking down at my phone

☐ During stressful situations

☐ At the end of the day

☐ After sleeping

☐ Randomly

☐ Other

## What seems to make your neck discomfort worse?

*(Check all that apply.)*

☐ Stress

☐ Clenching my teeth

☐ Grinding my teeth

☐ Looking down for long periods

☐ Poor posture

☐ Turning my head

☐ Lifting

☐ Working at a computer

☐ Sleeping position

☐ Other

## What helps relieve your neck discomfort?

*(Check all that apply.)*

☐ Rest

☐ Heat

☐ Ice

☐ Massage

☐ Stretching

☐ Medication

☐ Physical therapy

☐ Relaxation

☐ Changing positions

☐ Nothing seems to help

☐ Other

## Have you noticed any of the following?

*(Check all that apply.)*

☐ Limited range of motion

☐ Difficulty turning my head

☐ Neck stiffness

☐ Muscle tightness

☐ Muscle spasms

☐ Pain that spreads into my shoulders

☐ Pain that spreads into my upper back

☐ Pain that spreads into my head

☐ Tingling in my arms or hands

☐ Numbness in my arms or hands

☐ Weakness in my arms

**Please rate your neck discomfort.**

**0 1 2 3 4 5 6 7 8 9 10**

**What is the primary reason you are seeking treatment today? *(Choose the one symptom that concerns you the most.)***

☐ Jaw pain

☐ Head pain or headaches

☐ Neck pain

☐ Ear pain or ear pressure

☐ Jaw clicking or popping

☐ Jaw locking

☐ Difficulty opening my mouth

☐ Pain while chewing

☐ Jaw fatigue or tiredness

☐ My bite feels different

☐ Facial pain

☐ Tooth pain or sensitivity

☐ Ringing in the ears (tinnitus)

☐ Dizziness or balance problem

## History of Injury or Trauma

Some TMJ symptoms begin or become worse after an injury, accident, dental procedure, or other traumatic event. Understanding your history can help us determine whether an event may have contributed to your condition.

## Do you believe your symptoms began or became worse following an injury, accident, or traumatic event?

☐ Yes

☐ No

☐ I'm not sure

## If yes, which of the following may have contributed to your symptoms?

*(Check all that apply.)*

☐ Motor vehicle accident (MVA)

☐ Whiplash injury

☐ Sports-related injury

☐ Fall

☐ Direct blow to the face or jaw

☐ Work-related injury

☐ Dental procedure

☐ Wisdom tooth extraction

☐ Orthodontic treatment (braces or clear aligners)

☐ Prolonged mouth opening during a dental procedure

☐ Other traumatic event

☐ Other

## Approximately when did this occur?

☐ Within the past 6 months

☐ 6–12 months ago

☐ 1–5 years ago

☐ More than 5 years ago

☐ I don't remember

Approximate date (if known):

## When did your symptoms begin?

☐ Immediately after the event

☐ Within a few days

☐ Within a few weeks

☐ Several months later

☐ I'm not sure

## Sleep & Airway Screening

**Your sleep quality and airway health can play an important role in TMJ disorders. Please answer the following questions as accurately as possible.**

### Have you ever been told that you snore?

☐ Yes

☐ No

☐ I'm not sure

### Has anyone ever noticed that you stop breathing or gasp for air while sleeping?

☐ Yes

☐ No

☐ I'm not sure

### Do you wake feeling rested?

☐ Always

☐ Usually

☐ Sometimes

☐ Rarely

☐ Never

### Do you often experience any of the following?

*(Check all that apply.)*

☐ Daytime fatigue or excessive sleepiness

☐ Morning headaches

☐ Dry mouth upon waking

☐ Difficulty staying asleep

☐ Frequent nighttime awakenings

☐ Teeth clenching or grinding during sleep

☐ None of the above

## Have you ever been diagnosed with any of the following?

*(Check all that apply.)*

☐ Obstructive Sleep Apnea (OSA)

☐ Upper Airway Resistance Syndrome (UARS)

☐ Insomnia

☐ Restless Leg Syndrome

☐ Other sleep disorder

☐ None

## Have you ever been told you have any soft tissue abnormalities or airway conditions?

*(Check all that apply.)*

☐ Enlarged tonsils

☐ Enlarged adenoids

☐ Enlarged tongue (macroglossia)

☐ Tongue-tie (ankyloglossia)

☐ Elongated soft palate

☐ Deviated nasal septum

☐ Chronic nasal congestion

☐ Nasal obstruction

☐ Other

☐ None

## Have you ever had a sleep study?

☐ Yes

☐ No

If yes:

☐ Normal

☐ Diagnosed with sleep apnea

☐ I don't remember the results