TMJ DISORDER SCREENING QUESTIONNAIRE

Name: ____

Date: ____

1. Do you have difficulty opening your mouth? Y/N
2. Do you hear noises from the jaw joints? Y/N
3. Do you have frequent headaches? Y/N
4. Does your jaw get “stuck” or “locked”? Y/N
   Does it “go out”?
5. Do you have pain in or about the ears or cheeks? Y/N
6. Do you have pain on chewing or yawning? Y/N
7. Does your bite feel uncomfortable or unusual? Y/N
8. Have you had a recent injury to your head or neck? Y/N
9. Do you have arthritis? Y/N
10. Do you have any muscle or joint problems? Y/N
11. Have you ever been treated for temporomandibular Y/N
    disorders?