Dr. Larry M. Wolford treats temporomandibular joint (TMJ) pain and dysfunction. Please contact our office using our online contact form or call 214-828-9115 if you would like to schedule an appointment.

Temporomandibular Joint (TMJ) Pain Questionnaire

Do you have jaw joint pain, clinically known as temporomandibular joint (TMJ) pain? No ____ Yes ____
Is the pain? Mild ____ Moderate ____ Severe ____

Do you have TMJ noises when you open and close your mouth? No ____ Yes ____
Are the noises? Clicking ____ Popping ____ Grinding ____
Are the noises? Mild ____ Moderate ____ Severe ____
Is the pain in the TMJ on the Left ____ Right ____
Are the TMJ noises on the Left ____ Right ____

When did your jaw joint problems (i.e., pain, noises, headache) begin? Age ________ Year ______
What started your jaw joint problems? Injury ____ Disease ____ Unknown _____
Explain: __________________________________________________________

Have you had previous TMJ surgery? No ____ Yes ____
How many operations? Right TMJ ____ Left TMJ ____
Have your jaw alignment or bite changed? No ____ Yes ____
How much change? Mild ____ Moderate ____ Severe ____

Do you get headaches? No ____ Yes ____
Are the headaches: Mild ____ Moderate ____ Severe ____
Are your headaches worse in the:
Morning ____ Afternoon ____ Evening ____ Night ____ No Difference ____
How many headaches do you get? a week ____ a month ____
Are they: Occasional ____ Frequent ____ Constant ____

Where do the headaches occur?
Left Forehead ____ Right Forehead ____ Left Temple ____ Right Temple ____
Back of the Head ____ Top of Head ____ Behind Left Eye ____ Behind Right Eye ____

Do you have pain elsewhere? Neck ____ Shoulder ____ or Back pain ____
Is the pain: Mild ____ Moderate ____ Severe ____

Do you clench ____ and/or grind ____ your teeth at night? No ____ Yes ____
During the day? No ____ Yes ____
Is your clenching/grinding: Mild ____ Moderate ____ Severe ____
Do you get earaches? No ___ Yes ___ On which side? Left ___ Right ___
Are they: Mild ____ Moderate ____ Severe ____
Do they occur: Occasionally ____ Moderately ____ Frequently ____ Continuously ____

Do you get ringing in your ears? No ____ Yes ____
Is the ringing: Mild ____ Moderate ____ Severe ____
Does it occur: Occasionally ____ Moderately ____ Frequently ____ Continuously ____

Do you get lightheadedness or dizziness?
No ___ Yes ____ Is it Mild ____ Moderate ____ Severe ____
Does it occur: Occasionally ____ Moderately ____ Frequently ____ Continuously ____

Do you suffer from depression? No ____ Yes ____
Are you under treatment for depression? No ____ Yes ____

Do you have problems with other body joints? No ____ Yes ____
Please list the other joints: _________________________________________

Circle the number that best describes your jaw situation:

Temporomandibular Joint (TMJ) Pain
(No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Headache
(No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Average daily pain for head and neck area
(No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Rate your jaw function for opening, side to side movement, and chewing
Function Normal 0—1—2—3—4—5—6—7—8—9—10 No Function (Jaws Frozen)

What can you chew?
No Restriction (Chew Anything) 0—1—2—3—4—5—6—7—8—9—10 Liquids Only (Cannot Chew)

How much does your jaw problem affect your ability to carry out normal life activities?
No Interference In Any Way 0—1—2—3—4—5—6—7—8—9—10 Totally Disabled

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