NELSON R. DIERS, D.D.S., INC.

ORTHODONTIC AND TMJ TREATMENT FOR ADULTS AND CHILDREN

OCCLUSAL / TEMPOROMANDIBULAR JOINT EXAMINATION PATIENT QUESTIONNAIRE

NAME ____ AGE ______________

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS:

1. YES ☐ NO ☐ HAVE YOU EVER HAD ORTHODONTIC TREATMENT?
2. YES ☐ NO ☐ HAVE YOU EVER HAD PERIODONTAL DISEASE (PYORRHEA)?
3. YES ☐ NO ☐ HAVE YOU EVER BEEN TREATED FOR A "BAD BITE"?
4. YES ☐ NO ☐ DO YOU HAVE EXTENSIVE DENTAL CROWNS AND BRIDGES?
5. YES ☐ NO ☐ DO YOU WEAR A REMOVABLE PARTIAL DENTURE?
6. YES ☐ NO ☐ DO YOU HAVE MISSING BACK TEETH AND NO REPLACEMENT?
7. YES ☐ NO ☐ HAVE YOU BEEN TREATED FOR PROBLEMS OF YOUR JAW JOINT,OR FOR FACIAL MUSCLE SPASMS?
8. YES ☐ NO ☐ DO YOU EVER AWAKEN WITH AWARENESS OF YOUR TEETH OR JAWS?
9. YES ☐ NO ☐ ARE YOU AWARE OF CLENCHING YOUR TEETH DURING THE DAY?
10. YES ☐ NO ☐ HAVE YOU EVER BEEN TOLD THAT YOU GRIND YOUR TEETH DURING YOUR SLEEP?
11. YES ☐ NO ☐ DO YOUR TEETH HURT FROM BITING?
12. YES ☐ NO ☐ DO YOU HAVE ANY PAIN OR SORENESS AROUND YOUR EYES, EARS OR OTHER PARTS OF YOUR FACE?
13. YES ☐ NO ☐ DO YOU HAVE "TENSION" HEADACHES?
14. YES ☐ NO ☐ DO YOU EVER HAVE MIGRAINE HEADACHES?
15. YES ☐ NO ☐ DO YOU FREQUENTLY HAVE NECKACHES OR STIFF NECK MUSCLES?
16. YES ☐ NO ☐ DO YOUR JAW MUSCLES BECOME TIRED FREQUENTLY?
17. YES ☐ NO ☐ DO YOU HAVE DIFFICULTY IN OPENING YOUR MOUTH WIDE?
18. YES ☐ NO ☐ DO YOU HAVE DIFFICULTLY IN SWALLOWING?
19. YES ☐ NO ☐ HAVE YOU EVER HAD ARTHRITIS?
20. YES ☐ NO ☐ HAVE YOU EVER HAD GOUT?
21. YES ☐ NO ☐ HAVE YOUR EVER RECEIVED A SEVERE BLOW TO THE SIDE OF YOUR HEAD OR JAW?
22. YES ☐ NO ☐ HAVE YOU EVER HAD PAIN IN YOUR JAW JOINT?
23. YES ☐ NO ☐ HAVE YOU EVER HAD PROBLEMS WITH YOUR EARS, SUCH AS RINGING OR CHANGE OF HEARING?
24. YES ☐ NO ☐ DO YOU EVER HEAR GRATING SOUNDSFROM YOUR JAW JOINT?
25. YES ☐ NO ☐ DO YOU EVER HEAR CLICKING OR POPPING SOUNDS FROM YOUR JAW JOINT?
26. YES ☐ NO ☐ DO YOU FEEL YOUR TEETH MEET EVENLY?
27. YES ☐ NO ☐ ARE YOU PRESENTLY IN ANY PAIN FROM YOURJAW JOINT OR MUSCLES?
28. YES ☐ NO ☐ DOES PAIN OR DISCOMFORT FROM YOUR JAW JOINT INTERFERE WITH YOUR WORK OR ACTIVITIES?
29. YES ☐ NO ☐ ARE THERE TIMES WHEN YOU NOTICE THAT THIS PROBLEM OR PAIN IS LESS OR GONE COMPLETLEY?
30. YES ☐ NO ☐ ARE YOU AFRAID YOUR PROBLEM IS SERIOUS?
31. YES ☐ NO ☐ DO YOU FEEL YOU NEED TREATMENT FOR THIS PROBLEM?
32. YES ☐ NO ☐ DO YOU HAVE A PROBLEM WITH INSOMNIA?
33. YES ☐ NO ☐ DO YOU TAKE ASPIRIN FREQUENTLY?
34. YES ☐ NO ☐ ARE YOU TAKING ANY TRANQUILIZERS, HYPNOTICS, MUSCLE RELAXANTS OR ANTI DEPRESSANTS?
35. YES ☐ NO ☐ DO YOU TAKEMORE THAN ONE ALCOHOLIC DRINK PER DAY?
36. YES ☐ NO ☐ DO YOU SMOKE CIGARETTES, CIGARS OR A PIPE?
37. YES ☐ NO ☐ DO YOU BITE YOUR NAILS, TONGUE OR LIPS?
38. YES ☐ NO ☐ DO YOU HAVE YOUNG CHILDREN IN YOUR CARE?
39. YES ☐ NO ☐ DO YOU USUALLY EAT BREAKFAST?
40. YES ☐ NO ☐ DO YOU HAVE ANY PROBLEMS WITH EATINGOR CHEWING?

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NAME ____________________ MALE FEMALE AGE ________

1. HOW AND WHEN DID YOU BECOME AWARE OF YOUR NEED FOR AN EXAMINATION? ____________________

____

2. WHY DID YOU SELECT THIS PRACTICE? ____________________

____

3. CHIEF COMPLAINT ? ____________________

____

4. DOES YOUR JAW MAKE A POPPING NOISE __________ CLICKING __________ GRINDING __________

   OR OTHER NOISES? IF SO WHEN ____________________

5. DID YOUR JAW EVER POP, CLICK OR GRIND? ____________________

____

6. HAS YOUR JAW EVER LOCKED (CAN'T OPEN OR CAN'T CLOSE) OR SLIPPED OUT OF PLACE? __________

7. HAVE YOU EVER HAD AN INJURY TO YOUR NECK (WHIPLASH)? ☐ YES ☐ NO

8. DO YOU SUFFER FROM FREQUENT HEADACHES, OR NECK PAIN? ☐ YES ☐ NO

9. DOES YOUR NECK EVER MAKE CLICKING, GRATING, OR POPPING NOISES OR MOVEMENTS? ☐ YES ☐ NO

10. DOES IT HURT WHEN YOU TURN OR BEND YOUR NECK OR HEAD? ☐ YES ☐ NO

11. DOES YOUR HEAD OR NECK EVER GET STUCK MOMENTARILY IN A POSITION SO YOU CANNOT MOVE IT? ☐ YES ☐NO

12. IS YOUR NECK PAIN WORSE IN WAKING? ☐ YES ☐ NO

13. DO YOU HAVE PAIN OR NUMBNESS IN YOU ARMS, FINGERS OR HANDS? ☐ YES ☐ NO

14. DO YOU HAVE PAINFUL SENSATIONS OR NUMBNESS IN THE HEAD, NECK OR SHOULDER? ☐ YES ☐ NO

15. IS YOUR SLEEP DISTURBED BY PAIN OF THE HEAD AND NECK REGION? ☐ YES ☐ NO

16. ARE YOUR DAILY ACTIVITIES OR ROUTINE DISTURBED BY PAIN OF THE HEAD AND NECK REGION? ☐ YES ☐ NO

17. HAVE YOU EVER HAD A TRAUMATIC INJURY? ☐ YES ☐ NO

    INJURY TO JAW R ( ) L ( ) ON DATE ____________________

    INJURYTO NECK ON DATE ____________________

    INJURY TO HEAD ON DATE ____________________

    INJURY TO SPINE ON DATE ____________________

18. ORAL SYMPTOMS ☐ YES ☐ NO OR HABITS ☐ YES ☐ NO

- ☐ JAWS CLENCHED UPON WAKING
- ☐ CLENCHING DURING SLEEP
- ☐ GRINDING DURING SLEEP
- ☐ MUSCLE FATIGUE
- ☐ CLENCHING WHILE AWAKE
- ☐ GRINDING WHILE AWAKE
- ☐ GINGIVA BLEEDING
- ☐ FACIAL SWELLING
- ☐ OTHER

19. BALANCE PROBLEMS ☐ YES ☐ NO

- ☐ VERTIGO (DIZZINESS)
- ☐ FAINTING
- ☐ OTHER
- ☐ FREQUENCY

WHEN ______________________________

20. HEARING PROBLEMS ☐ YES ☐ NO

- ☐ RINGING R ( ) L ( ) PITCH H ( ) L ( )
- ☐ POPPING/WHOOSING AWAKENING R ( ) L ( )
- ☐ HEARING LEVEL CHANGES IN R ( ) L ( )
- ☐ OTHER

21. PREVIOUS PROFESSIONAL TREATMENT: YES ☐ NO ☐ - (QUSTIONS 17-20)

PROFESSIONAL: ______________________ TREATMENT: ______________ HELP? YES ☐ NO ☐

PROFESSIONAL: ______________________ TREATMENT: ______________ HELP? YES ☐ NO ☐

PROFESSIONAL: ______________________ TREATMENT: ______________ HELP? YES ☐ NO ☐

PROFESSIONAL: ______________________ TREATMENT: ______________ HELP? YES ☐ NO ☐

22. IS PRESENT STRESS HIGHER THAN USUAL? ☐ YES ☐ NO

22. OTHER CONCERNS? ☐ YES ☐ NO

- ☐ CROOKED JAW ______________________________
- ☐ OTHER ______________________________

23. OVERALL FEELING TODAY RATE FROM 1-10 ______________________________

(1 = LOWEST FEELING - 10=HIGHEST FEELING)

24. ARE YOU WEARING AN APPLIANCE NOW? IF YES WHAT TYPE? ______________________________

WHEN WAS IT PLACED? ______________________ BY WHOM? ______________________

HAVE YOUR SYMPTOMS IMPROVED OR CHANGED? ☐ YES ☐ NO

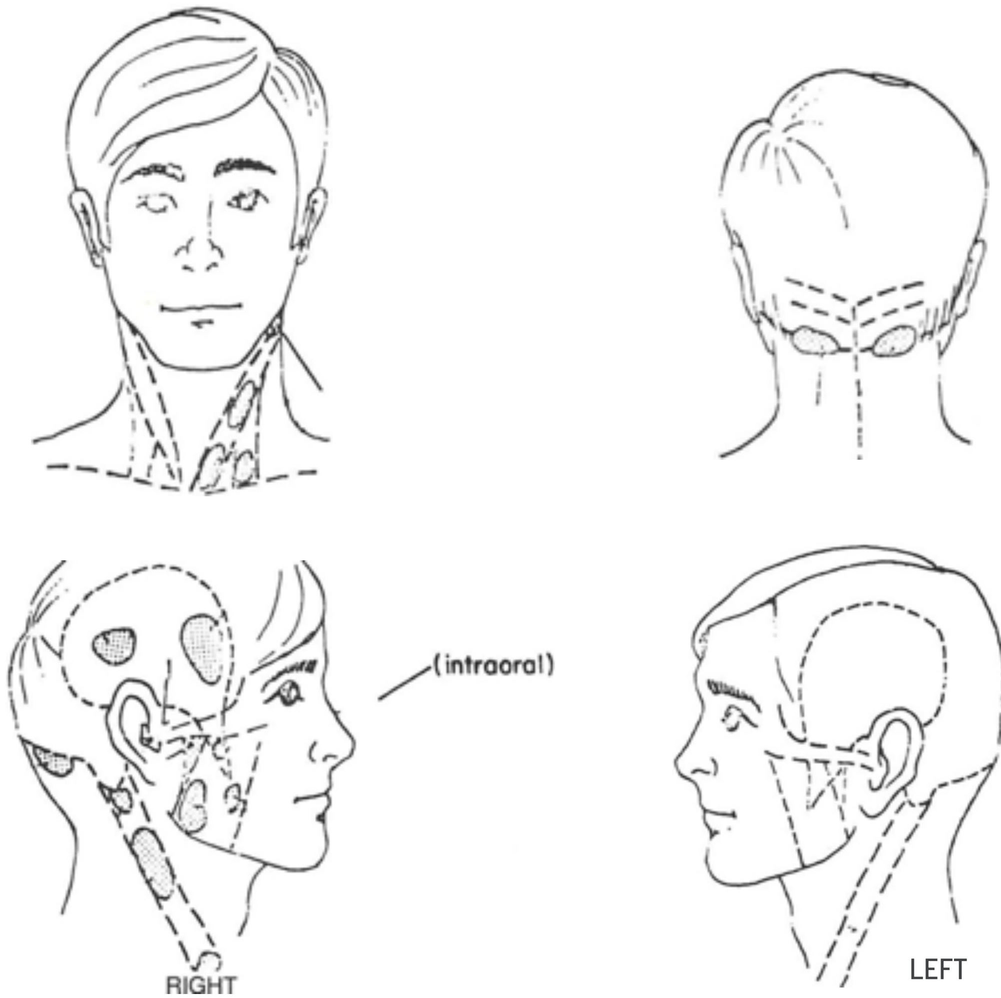
COMMENTS: ______________________________

____

____

____

SEQUENCE AND SITES FOR PALPATION



ON DIAGRAM MARK LOCATION OF PRINCIPLE PAINS. IF PAIN SPREADS FROM PRIMARY AREA INDICATE DIRECTION WITH ARROW. LABEL MOST SEVERE PAIN WITH #1, SECOND MOST SEVERE WITH #2, ETC.

NUMBER TYPE OF PAIN ON CHART BELOW.

PAIN TYPE:	☐ MILD	☐ SEVERE	☐ DULL	☐ PRICKLING
	☐ SHARP	☐ ITHCHING	☐ BURNING	☐ ACHING
	☐ PULSING	☐ STEADY		☐ SPONTANEOUS
DURATION:	☐ CONSTANT	☐INTERMITTENT		☐ RECURRENT
	☐ MOMENTARY	☐ MINUTES	☐ HOURS	☐ ALL DAY
	☐ DAYS	☐ WEEKS	☐ MONTHS	☐ OTHER ______
LOCATION:	☐ DIFFUSE	☐ LOCALIZED TO: ______		
	☐ ENLARGING	☐ MIGRATING		☐ OTHER
	☐ TEMPLES REGION	☐ IN FRONT OF EARS		☐ CHEEKBONE
	☐ BEHIND EAR	☐ BELOW EARS	☐ IN JAW	☐ BEHIND & BELOW EARS
AFFECTED BY:	☐ FACE MOVEMENT	☐ JAW MOVEMENTS	☐ SWALLOWING	☐ TONGUE MOVEMENT
	☐ HEAD POSITION	☐ ACTIVITY	☐ BODY POSITION	☐ TENSION
	☐ FATIGUE	☐ TIME OF DAY: ______		

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PRACTICE LIMITED TO ORTHODONTIC AND TMJ TREATMENT FOR ADULT AND CHILDREN

LIFE EVENTS QUESTIONNAIRE

		WITHIN 2 YEARS	WITHIN 6 MONTHS	YOUR SCORE
1.	DEATH OF SPOUSE	75	100	
2.	DIVORCE	63	84	
3.	MARITAL SEPARATION	51	70	
4.	JAIL TERM	45	63	
5.	DEATH OF A CLOSE FAMILY MEMBER	44	62	
6.	PERSONAL INJURY OR MAJOR ILLNESS	37	53	
7.	MARRIAGE	34	50	
8.	FIRED FROM WORK	32	47	
9.	MARITAL RECONCLI IATION	30	45	
10.	RETIREMENT	30	45	
11.	CHANGE IN THE HEALTH OF A FAMILY MEMBER	29	44	
12.	PREGNANCY	26	40	
13.	SEXUAL DIFFICULTIES	25	39	
14.	GAIN OF A NEW FAMILY MEMBER	24	39	
15.	BUSINESS RE-ADJUSTMENT	24	39	
16.	MARRIAGE OF A DAUGHTER	23	38	
17.	CHANGE IN FINANCIAL STATE	22	38	
18.	DEATH OF A CLOSE FRIEND	21	37	
19.	CHANGE TO ENTIRELY DIFFERENT LINE OF WORK	21	36	
20.	CHANGE IN RESIDENCE	20	36	
21.	CHANGE IN NUMBER OF ARGUMENTS WITH SPOUSE	19	35	
22.	VERY LARGE MORTGAGE	17	31	
23.	FORECLOSURE OF MORTGAGE OR LOAN	16	30	
24.	CHANGE OF RESPONSIBILITIES AT WORK	15	29	
25.	MARRIAGE OF SON	15	29	
26.	SON OR DAUGHTER LEAVING HOME	14	29	
27.	TROUBLE WITH IN-LAWS	14	29	
28.	OUTSTANDING PERSONAL ACHIEVEMENT	13	28	
29.	SPOUSE BEGINS OR STOPS WORK	12	26	
30.	BEGIN OR END OF SCHOOL	11	25	
31.	CHANGE IN SCHOOLS	11	25	
32.	REVISION OF PERSONAL HABITS	10	24	
33.	TROUBLE WITH BOSS	9	23	
34.	CHANGE IN SLEEPING HABITS	8	21	
35.	CHANGE IN WORK HOURS OR CONDITIONS	8	20	
36.	CHANGE IN RECREATION	7	19	
37.	CHANGE IN CHURCH/TEMPLE ACTIVITIES	7	19	
38.	CHANGE IN SOCIAL ACTIVITIES	6	18	
39.	SMALL MORTGAGE OR LARGE PERSONAL LOAN	6	17	
40.	CHANGE IN NUMBER OF FAMILY GET TOGETHERS	5	15	
41.	CHANGE IN EATING HABITS	5	15	
42.	VACATION	4	13	
43.	LARGE CHRISTMAS/HANUKKAH CELEBRATION	4	12	
44.	MINOR VIOLATIONS OF THE LAW	3	11	

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