

TMJ SCREENING FORM

Patient Name: _____

Date: ____/____/____

SYMPTOMS	YES	NO	DETAILS:
HEADACHES			
TMJ PAIN			
TMJ NOISE			
LIMITED JAW OPENING			
EAR CONGESTION			
VERTIGO / DIZZINESS			
RINGING IN THE EARS / TINNITUS			
DYSPHAGIA / DIFFICULTY SWALLOWING			
LOOSE TEETH			
GRINDING - CLENCHING/ BRUXING			
FACIAL PAIN TENDER (NONSPECIFIC)			
SENSITIVE TEETH - HOT/COLD			
TENDERNESS ON BITING / PERCUSSION			
DIFFICULTY CHEWING			
CERVICAL PAIN			
POSTURAL PROBLEMS			
TINGLING OF FINGERTIPS / PARESTHESIA			
BELL'S PALSY			
NERVOUSNESS			
INSOMNIA			
SPEECH ABNORMALITIES			
OTHER:			