Name Date D.O.B.  Fill in the appropriate response indicating whether or not you currently have, previously had the following conditions or symptoms.  1. Have you had Orthodontic treatment? yes no 15. Do you have neck aches? yes no 2. Wisdom teeth removed? yes no 16. Sinus problems? yes no 3. Do you chew gum regularly? yes no 17. Do you have sleep apnea? yes no 3. Treated for a "bad bite"? yes no 18. Do you have sleep apnea? yes no 4. TMJ (jaw joint) treatment? yes no 19. Earaches or ear pain? yes no 5. Sore or sensitive teeth? yes no 20.Grating noises in ears 6. Do you have chronic headaches? yes no 21. Are your teeth badly worn? yes no 7. Do you have tension headaches? yes no 22.Pain in, around, or behind eyes? yes no 10. Do you have ear pain? yes no 23. Are you under a lot of stress? yes no 11. Does it hurt to open wide? yes no 12. Do you have difficulty chewing? yes no 13. Does your jaw ache when you chew? yes no 14. Pain in teeth on awakening? yes no 15. Do you grind your teeth at night? yes no 5. Does it hurt to open your mouth widely? yes no 6. Has your jaw ever locked and made you unable to open/close your mouth? yes no 6. Has your jaw ever locked and made you unable to open/close your mouth? yes no
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6. Has your jaw ever locked and made you unable to open/close your mouth? yes no
7. Do your jaws make a clicking or popping sound when you chew? yes no
8. Is it painful to yawn yes no
9. Do you have pain in your neck/shoulders?
10. Have you ever had a severe blow to the head?
11. Have you ever had a night guard/sp[int? yes no
12. Do you currently wear a night guard/splint?
13. Paín ín Ríghtjawjoint? yes no
14. Paín in left jaw joint?
15. Do you hear sound in your jaw joint?
16. Do you have generalized facial pain?  yes no
If yes, which side? right left
On a scale from 1 - 10 please rate your current level of pain of your jaw joints
The second form and form the form the second of the second form decrees
1 2 3 4 5 6 7 8 9 10 Low moderate high