Date:______________________________

1. Name ________________________ Age:_____________ Phone:____________
2. Address ______________________ City_____________________State_______
3. Referred by Dr.____________________________
4. Do you have headaches?____________Neck pain?____________Jaw Pain?__________
   Ear pain?________ Face pain?________ Eye Pain?_________Other?______________
   Which side hurts? Right_______ Left __________Both _________________
5. How long have you had these symptoms? _________years _______months _____days_____
6. Is the pain constant? ___________aching? __________ shooting? ______________
   Burning?_______________ stabbing?___________electrical?__________ other______
   Worse in morning?__________________Worse in afternoon?_________________
7. Does it hurt to chew? _____________ Open wide?__________________________
8. Does your jaw make a popping noise?_________________________Clicking?________
   Grinding?__________________Other?_____________________________
9. Has your jaw ever "locked" or slipped out of place?___________________________
10. Do you ever clench or grind your teeth?______________________________
    At night?________________________during the day?__________________
11. Do you have problems with your ears?_______________ hearing________________
    Dizziness?___________________ other?_____________________________
12. Is it difficult to swallow?____
13. Are your teeth sore or sensitive?_____________________________________
14. Are you taking medicine of any kind?___________________ What for?_____________
15. Have you ever been treated for this problem by any other doctor?______________
    If so, Name ______________________________
    Address______________________________
    Treatment______________________________
16. Describe your problem in your own words (use back if necessary)____________________