

1. What are your chief complaints? List from most to least important.

1. _____
2. _____
3. _____

Other symptoms (please write in).

2. Do symptoms affect one or both joints? Right () Left () Both ()

If both joints, indicate which joint seems most affected _____ L _____ R

3. How many years, months, weeks or days have you been bothered by this problem?

a. _____ years b. _____ months c. _____ weeks d. _____ days

4. Have you had any injury to the jaw or face? ___ Yes No ___

5. Do you have arthritis? ___ Yes No ___

6. Have you ever had cervical traction? ___ Yes No ___

7. Have you ever worn a neck brace? ___ Yes No ___

8. Have you had any other treatment for this problem? ___ Yes No ___

(If yes, explain – medicine, exercise, dental appliances such as a splint, or night guard.)

9. Have you had your teeth straightened (orthodontia)? ___ Yes No ___

10. Have you had teeth removed for orthodontia? ___ Yes No ___

11. Have you had your wisdom teeth removed? ___ Yes No ___

12. Have you ever had general anesthesia? ___ Yes No ___

13. Did you have allergies as a child? Unknown ___ Yes ___

14. Have you had your bite adjusted by your dentist? (equilibration) ___ Yes No ___

(If yes please explain when)

15. Do you attribute the symptoms to any one incident? ___ Yes No ___

(If yes, explain) _____

16. Have you had cortisone injected into joint? ___ Yes No ___

If yes, when? _____ How many injections? _____

By whom? _____