Tom Laster, DDS

Questionnaire

Client's Name: _____ Date: _____

For each question, circle either "Y" for Yes, or "N" for No.

1. Y N Do you have difficulty or pain in your jaw from chewing, talking or at a dental visit?
2. Y N Do you have any pain or difficulty getting your mouth open widely on awakening or yawning?
3. Y N Do you have frequent pain in or near your ear(s), temples or cheeks?
4. Y N Do you have frequent headaches?
5. Y N Do you have noises in either jaw joint such as clicking, popping, grating or grinding?
6. Y N If our jaw joints do not make any noise, have they in the past?
7. Y N Does your jaw ever get "stuck", catches, or "go out" on opening? (or has this occurred any time in the past?)
8. Y N Are you aware of clenching or grinding your teeth?
9. Y N Does your bite feel unusual or uncomfortable?
10. Y N Do you chew or accidentally bite your lip, cheeks or tongue?
11. Y N Have you had a recent injury to your head, face or jaw?
12. Y N Have you previously been treated for a jaw problem?
13. Y N If you answered "yes" to any of the above, are any of these symptoms present more at the time you awaken?

Describe in your own words any pain of your head or neck area that occurs on a regular basis:

Patient Signature: _____

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