TMD/EMG FOLLOW-UP FORM

Name_____

Date_____

Session #_____

Discomfort

On a scale of 1 to 5, how would you measure the ***discomfort***?

Low High

☐1 ☐2 ☐3 ☐4 ☐5

How many days of the month do you have the ***discomfort***?

☐1-5 ☐6-10 ☐11-15 ☐16+

Pain

On a scale of 1 to 5, how would you measure the ***pain***?

Low High

☐1 ☐2 ☐3 ☐4 ☐5

How many days of the month do you have the ***pain***?

☐1-5 ☐6-10 ☐11-15 ☐16+

When you get pain, how many hours does the ***pain*** last?

☐1-5 ☐6-10 ☐11-15 ☐16+

Headache

On a scale of 1 to 5, how would you measure the ***headache***?

Low High

☐1 ☐2 ☐3 ☐4 ☐5

How many days of the month do you have the ***headache***?

☐1-5 ☐6-10 ☐11-15 ☐16+

When you get a headache, how many hours does the ***headache*** last?

☐1-5 ☐6-10 ☐11-15 ☐16+