TMD/EMG FORM

Name_____

Date_____

Session #_____

Please complete this questionnaire to tell us more about your discomfort, pain and/or headaches.

Discomfort

What area(s) of the Head & Neck do you have ***discomfort***?

- ☐Front of the face
- ☐Side of the Face
- ☐Back of the Head
- ☐Lower jaw
- ☐Other

How long have you had discomfort?

☐<1yr ☐1-5yr ☐5-10yr ☐>10yr

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

What area(s) of the Head & Neck do you have ***Pain***?

- ☐Front of the face
- ☐Side of the Face
- ☐Back of the Head
- ☐Lower jaw
- ☐Other

How long have you had ***pain***?

☐<1yr ☐1-5yr ☐5-10yr ☐>10yr

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

What area(s) of the Head & Neck do you have ***Headache***?

☐Front of the face
☐Side of the Face
☐Back of the Head
☐Lower jaw
☐Other

How long have you had ***headache***?

☐<1yr ☐1-5yr ☐5-10yr ☐>10yr

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+

Describe the source of the pain .

☐focal ☐one side ☐both sides ☐deep ☐radiating
☐other…….

Describe the type of pain.

☐electric ☐piercing ☐shooting ☐constant ☐dull

☐throbbing ☐other…….

Does the pain effect the following?

☐eating ☐sleeping ☐talking ☐working ☐brushing teeth
☐other…….

Do you find yourself grinding your teeth?

☐during the day ☐during the night ☐always

What other treatments have you undergone?

☐medications ☐Hypnosis ☐biofedback ☐acupuncture ☐injections
☐Physiotherapy ☐craniosacral physiotherapy
☐chiropractic ☐massage ☐psychiatric ☐Tens
☐oral appliance /splint
☐other……

Do your symptoms effect the following?

☐work ☐marriage ☐leisure ☐children

What part of the day do you experience symptoms?

☐morning ☐afternoon ☐evenings ☐always

Is there a trigger(s) that set the symptoms off?

☐No ☐Yes

Is there a threshold?

☐No ☐Yes

Have you been told that you snore when resting or sleeping?

☐No ☐Yes