DYSFUNCTION QUESTIONNAIRE

NAME:______________________________ DATE:______________

1. Do you have a grating, clicking or popping sound in either or both jaws when you chew? ☐Yes ☐No
2. Do you have sensations or stuffiness, pressure or blockage, ringing, hissing or buzzing in your ears? ☐Yes ☐No
3. Do you ever feel dizzy or faint? ☐Yes ☐No
4. Is your jaw painful or locked when you wake up in the morning? ☐Yes ☐No
5. Do you consider yourself chronically fatigued? ☐Yes ☐No
6. Are you ever nauseated for no apparent reason? ☐Yes ☐No
7. Do your fingers sometimes go numb? ☐Yes ☐No
8. Check any area where you have pain or soreness:

   ☐Jaw joints ☐Upper jaw or teeth ☐Back of head
   ☐Forehead ☐Lower jaw or teeth ☐Chewing muscles
   ☐Temples ☐Side of neck ☐Behind the eyes
   ☐Tongue

9. Is it hard to move your jaw side-to-side, forward or backward? ☐Yes ☐No
10. Do you have difficulty chewing? ☐Yes ☐No
11. Do you have back teeth missing? ☐Yes ☐No
12. Have you had extensive dental crowns or bridgework? ☐Yes ☐No
13. Do you clench your teeth during the day? ☐Yes ☐No
14. Do you grind your teeth at night? (Ask someone else) ☐Yes ☐No
15. Do you ever have a headache when you wake up? ☐Yes ☐No
16. Have you had whiplash injury? ☐Yes ☐No
17. Have you worn a cervical collar or had neck trauma? ☐Yes ☐No
18. Have you ever had a blow to the chin, face or head? ☐Yes ☐No
19. Have you reached the point at which drugs no longer relieve your symptoms? ☐Yes ☐No
20. Does chewing gum start your symptoms? ☐Yes ☐No
21. Does your jaw deviate to the left or right when you open wide? ☐Yes ☐No
22. When your mouth is wide open, can you insert three fingers into your mouth vertically? ☐Yes ☐No
23. Please write a brief narrative of your past medical and dental history (including injuries) pertaining to the jaw joint:

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