

PLEASE FILL OUT COMPLETELY—ALL MATERIAL IS CONFIDENTIAL

NAME: _____ DATE: _____

QUESTIONNAIRE NO. 1

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. DOES IT HURT WHEN YOU CHEW? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. DOES IT HURT WHEN YOU OPEN WIDE OR TAKE A BIG BITE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DOES YOUR JAW MAKE NOISE SO THAT IT BOTHERS YOU OR OTHERS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DO YOU HAVE EAR PAIN OR PAIN IN FRONT OF THE EARS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU SUFFER FROM PAIN IN THE FACE, JAWS, EYES, THROAT, NECK, TEMPLES? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. DO YOU SUFFER FROM HEADACHES? | <input type="checkbox"/> | <input type="checkbox"/> |

QUESTIONNAIRE NO. 2

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. DOES THE PAIN OR DISCOMFORT DISTURB YOUR SLEEP? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. DOES PAIN OR DISCOMFORT INTERFERE WITH YOUR DAILY ACTIVITIES? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DO YOU TAKE TABLETS FOR RELAXATION? (VALIUM?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DO YOU TAKE TABLETS FOR PAIN OR DISCOMFORT? | <input type="checkbox"/> | <input type="checkbox"/> |

QUESTIONNAIRE NO. 3

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. HAS ANYONE HEARD YOU GRINDING IN YOUR SLEEP OR ARE YOU AWARE OF IT? | <input type="checkbox"/> | <input type="checkbox"/> |
| LESS THAN TWO WEEKS AGO | <input type="checkbox"/> | <input type="checkbox"/> |
| GREATER THAN TWO WEEKS | <input type="checkbox"/> | <input type="checkbox"/> |
| GREATER THAN ONE MONTH | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ARE YOU AWARE THAT YOU CLAMP OR "SET" YOUR TEETH? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS UPON WAKING IN THE A.M.? | <input type="checkbox"/> | <input type="checkbox"/> |
| STIFF JAW? | <input type="checkbox"/> | <input type="checkbox"/> |
| SORE JAW OR TEETH? | <input type="checkbox"/> | <input type="checkbox"/> |
| CRACKING OR LOCKING OF THE JAW JOINT? | <input type="checkbox"/> | <input type="checkbox"/> |
| HEADACHE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DOES YOUR JAW "FEEL TIRED" AFTER A BIG MEAL? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. MUST YOU CHEW ON ONE SIDE EXCLUSIVELY? | <input type="checkbox"/> | <input type="checkbox"/> |

QUESTIONNAIRE NO. 4

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. HAVE YOU EVER HAD NECK, SHOULDER, OR BACK PAIN? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. HAVE YOU EVER HAD A "WHIPLASH"? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. HAVE YOU EVER HAD "NERVOUS STOMACH" OR ULCERS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. HAVE YOU EVER HAD BOWEL TROUBLE, CONSTIPATION OR COLITIS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU HAVE ARTHRITIS? | <input type="checkbox"/> | <input type="checkbox"/> |

SIGNATURE: _____

DATE: _____

- JOINTS**
- (1) LATERAL TO CAPSULE
 - (2) DORSAL TO CAPSULE (VIA EAR)

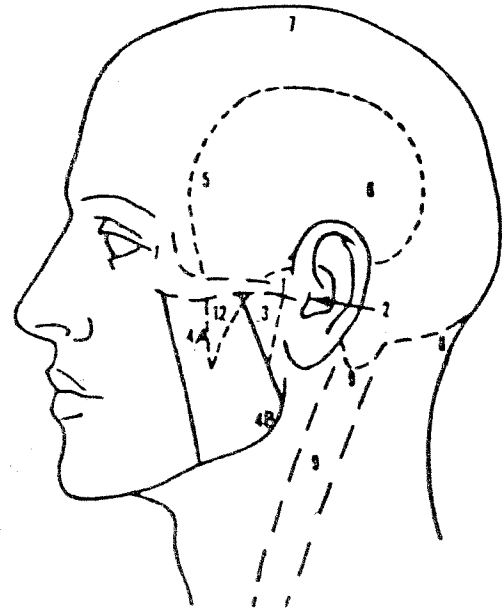
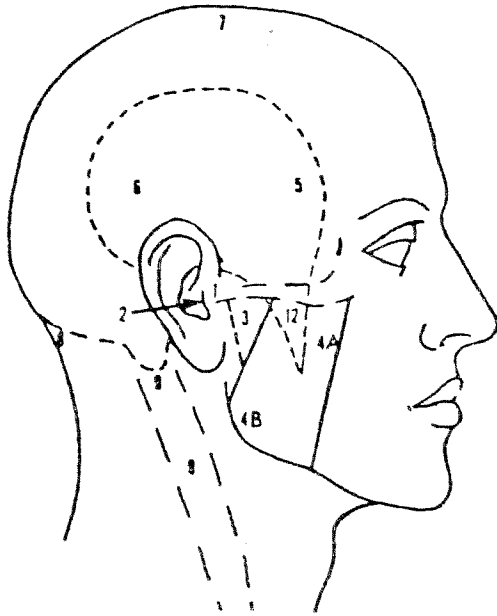
- EXTRAORAL MUSCULATURE**
- (3) DEEP MASSETER
 - (4) SUPERFICIAL MASSETER
 - (5) ANT. TEMPORAL
 - (6) POST. TEMPORAL

- (7) VERTEX
- (8) NECK
- (9) STERNOCLEIDOMASTOID
- (10) MEDIAL PTERYGOID
- (11) POST. DIGASTRIC

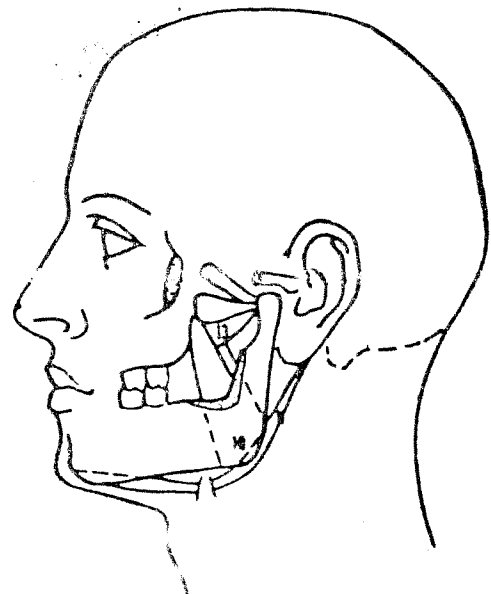
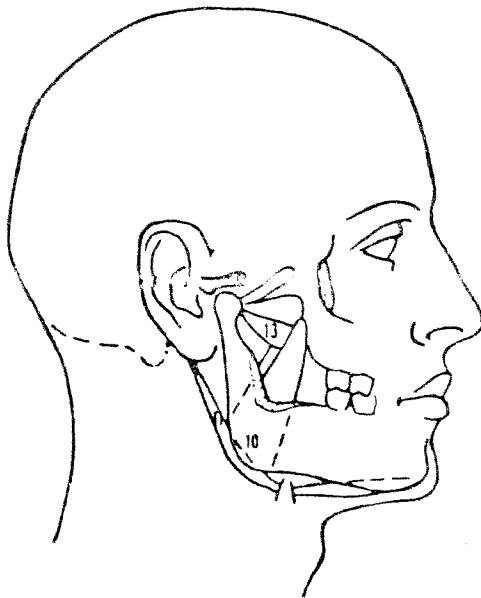
- INTRAORAL MUSCULATURE**
- (12) TEMPORALIS TENDON
 - (13) LATERAL PTERYGOID

PATIENT SYMPTOMS — CIRCLE AREA IN BLUE
POSITIVE PALPATIONS — MARK RED "X"
 (SEE BELOW)
 (X) DIFFERENCE BETWEEN MUSCLE PAIRS, BUT ONLY "UNCOMFORTABLE" PLUS "IT HURTS"
 (X) DIFFERENCE BETWEEN MUSCLE PAIRS, PLUS DRAMATIC PAINFUL RESPONSE
TRIGGER POINT — MARK GREEN "ARROW" TO TRACE PATH FROM TRIGGER POINT TO REFERENCE AREA.

MUSCLE AND JOINT TENDERNESS ON PALPATION



"DO YOU FEEL ANY DIFFERENCE BETWEEN THE TWO SIDES?"
 "DOES IT HURT OR IS IT JUST UNCOMFORTABLE?"



SYMPTOM REVIEW

- ___ DIFFICULTY OPENING
- ___ LOCKING
- ___ DISLOCATION
- ___ CLICK
- ___ CREPITATION

- ___ EAR PAIN
- ___ TMJ PAIN
- ___ CHEEK PAIN
- ___ HEADACHE
- ___ NECK/BACKACHE
- ___ TEETH

- ___ FATIGUE
- ___ BITE UNCOMFORTABLE
- ___ THROAT SENSITIVITY
- ___ TONGUE SENSITIVITY
- ___ EYE SENSITIVITY
- ___ AUDITORY SENSATIONS
- ___ DIZZINESS