Joint Survey

Name_____ Date:_____

Joint Dysfunction

Y□ N□ Are you aware of joint sounds? (in the jaw)

Y□ N□ Did you ever have joint sounds?

Y□ N□ Do you have ear pain?

Y□ N□ Do you wake up with your jaws sore or tired?

Y□ N□ Do you ever have difficulty opening widely?

Y□ N□ Do you avoid eating certain foods because of pain or discomfort?

Y□ N□ Do you get headaches? How often?_____

Y□ N□ Has there been a change in your headache pattern?

Y□ N□ Does anything trigger your headaches?

To what degree would you say your headaches effect your life? (circle one)

Not at all Rarely Occasionally Regularly Often

On a scale from one to ten, what is the pain level of your headaches?_____

Have you been treated or evaluated for your headaches?_____

Sleep

Y□ N□ Do you snore?

Y□ N□ Do you have high blood pressure?

Y□ N□ Has anyone reported that you choke or gasp for air while sleeping?

Y□ N□ Do you wake refreshed?

Y□ N□ Are you excessively tired during the day?