

**PRINCETON PARK DENTAL ASSOCIATES, P.A.
JAW JOINT EVALUATION FORM**

PLEASE SELECT THE ANSWER THAT BEST APPLIES TO YOU

- Do you have facial or jaw pain? Never Rarely Sometimes Often
- Are you aware of clenching or grinding your teeth either during the day or while sleeping? Never Rarely Sometimes Often
- Are you aware of your jaw clicking or popping while eating or yawning? Yes No
If yes, is the clicking painful? Yes No
- Do you ever have difficulty opening your mouth widely? Never Rarely Sometimes Often
- Is your jaw sore or tired upon wakening? Never Rarely Sometimes Often
- Has your jaw ever locked open or closed? Yes No
- Do you experience morning headaches? Yes No How often? _____
- Do you experience migraine headaches? Yes No How often? _____
- Do you avoid harder consistency foods because eating them causes soreness? Yes No
- Were you ever diagnosed with TMJ? Yes No
- Have you experienced ear pain or 'stuffiness' sensation? Yes No

The information I have provided in this questionnaire is true, accurate and complete to the best of my knowledge and I take full responsibility for the answers that I have provided.

I understand that the information supplied will only be disclosed to practitioners involved in my treatment and care and consent to such disclosure.

Date: (day/month/year) _____

Patient Signature: _____