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

Date: _____

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.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY: DO NOT WRITE BELOW THIS LINE

No Jaw Joint Related Issues ☐

No Active Decay ☐

Doctor Signature: _____