HEAD, NECK, TMJ, & FACIAL PAIN OR DYSFUNCTION
SCREENING QUESTIONNAIRE

(Please Print with Blue Ballpoint)

Name:____________________________ Date:________________________

Referred By:______________________ Current Dentist:_________________

1. One or more of the following symptoms may indicate a TMJ-Craniomandibular problem. If you have any of the following symptoms, please indicate by circling the appropriate descriptions around the drawing below. (R: Right Side; L: Left Side)

HEAD
1. Tension Headaches R L
2. Migraines R L
3. Chronic Headaches R L
4. Tender to Touch R L

EAR
1. Clogged R L
2. Ear Pain R L
3. Ringing, Buzzing R L
4. Dizziness R L

JAW
1. Clicks, Pops R L
2. Joint Pain R L
3. Grinding Noise R L
4. Facial Pain R L

NASAL
1. Sinus Pain
2. Post Nasal Drainage
3. Allergic Conditions

EYE
1. Red Eyes R L
2. Light Sensitive R L
3. Pain Behind Eyes R L
4. Tears in Eyes R L

MOUTH
1. Abnormal Opening
2. Bad Bite
3. Missing Jaw Teeth
4. Excessive Mouth Breathing
5. Grind/Clench on Teeth

NECK & SHOULDERS
1. Pain R L
2. Stiffness R L
3. Poor Posture
4. Swallowing Difficulties

2. If you routinely have any pain, mark in red on the drawing in which area of the head or neck this pain occurs.

3. How long has this been a problem for you? __________________________

4. Does this condition alter the quality of your life? _____________________

5. Do you feel that you need more information about TMJ Disorders? __________

6. Do you feel that the doctor should examine you further concerning this condition? ___________________________
Name ______________________________ Date ___________ Age _____ Sex _____

**CMO Screening Exam**

1. **Chief Complaints**
   1. __________________________________________________________
   2. __________________________________________________________
   3. __________________________________________________________
   4. __________________________________________________________

2. **Duration** ___________ **Better** ___________ **Worse** ___________
   
   **Frequency** ___________ **Severity** ___________
   
   **Quality of Pain** ____________________________

3. **TMJ Sounds:**
   - Opening Click: Yes/No Right/Left
   - Opening Crepitus: Yes/No Right/Left
   - Closing Click: Yes/No Right/Left

4. **Palpation of Muscles: Pain or Tenderness**
   1. Temporalis: Right/Left
   2. Masseter: Right/Left
   3. Coronoid: Right/Left
   4. Lat. Pterygoid: Right/Left
   5. Sternocleidomastoid: Right/Left
   6. Scalene: Right/Left
   7. Digastric: Right/Left
   8. Posterior Cervical: Right/Left
   9. Trapezius: Right/Left
   10. Rhomboid: Right/Left

5. **Occlusal Flags:**
   - Loss of Posterior Support: Right/Left/NSF
   - Wear Facets: Right/Left/NSF
   - Deep bite/over closure: Right/Left/NSF
   - Incisal Wear/chipping: Right/Left/NSF
   - Posterior cusp wear: Right/Left/NSF
   - Max Ant Thinning: Right/Left/NSF
   - Anterior crowding: Right/Left/NSF
   - Tooth filling/fracture: Right/Left/NSF
   - Fremitus: Right/Left/NSF
   - Lingual version Max. Anteriors: Right/Left/NSF

6. **Headaches** ___________ **Neckaches** ___________ **Ear** ________ **Eye** ________
   **Throat** ________ **Sinus** ________ **Jaw** ________ **Mouth** ________

7. **Comments:**
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

8. **Recommendations:**
   - Referral for further evaluation
   - Escalation to complete examination
   - No treatment indicated
On behalf of my staff and myself, I welcome you into our fine family of patients. One of the most important elements in our diagnosis and treatment is the documentation process. This information gathering process is essential to our getting to know you and our better understanding of the pain you have been suffering. We know this is time-consuming; we thank you for your co-operation, as it critical to successful treatment.

The Documentation will consist of a narrative of your present dilemma, and a “Treatment History” in which you will be asked to describe, in as great a detail as you can remember, the complete account of your difficulties.

1. Please put the account in chronological order starting with the first symptoms you experienced, the first physicians or dentists you visited for the problem, the first treatment and the results (good or bad).
2. Be sure to list facial and bodily areas where you experienced pain or any other abnormal sensations.
3. List any physicians, dentists, ear-nose-throat specialists, orthopedists, chiropractors, or clinical teams who have treated you. Briefly describe their diagnosis and treatment. Use additional pages as necessary.
4. List the medications you are now taking and have taken in the past for this condition. On a separate line, list the medicines you take for other conditions, if any, and describe those conditions.
5. Finally, please share with me the importance of your getting well. What is your sense of commitment in getting the results you desire? How much do you expect us to supply a magic answer, and how committed are you to making lifestyle changes for your own benefit?

If time permits, please mail or drop off your report to me before your next appointment with us.

Thanks for letting us help!

Dr. Bob Finkel
NARRATIVE
INFORMED CONSENT AGREEMENT

Temporomandibular Joint and Myofascial Pain can mimic other dental and medical problems. The diagnosis is very important because some of the medical problems that have similar headache or neckache symptoms can be life threatening: for example, intracranial tumor or coronary heart disease. You can help by giving the doctor a detailed medical and family history including a history of any food or drug allergies. Treatment for TM Joint/ Myofascial disorders can be lengthy and frustrating. You must inform the doctor about changes in jaw function; the best therapeutic improvement is a result of good patient-doctor communication. Please call our office anytime there is a problem or question about treatment.

Length of Treatment: Treatment time can vary widely. In general, the treatment plan will be more lengthy and complicated if the symptoms are severe, or if the problem has existed for a long time. Mild clicking with occasional muscle spasm headache may be successfully treated within a few weeks or months, but a long-standing arthritic joint disorder may require surgery, dental prosthetics, orthodontics, and/or extensive restorative treatment procedures.

Possible Complications: We will make our best effort to diagnose and treat any TM Joint disorder with timely and cost-effective methods. The most proven and conservative techniques will be used. However, you should be aware that there is much debate in the scientific literature on the most effective techniques and/or combination of treatment modalities. These include, but are not limited to, prosthetic splints, restorative and prosthetic dental procedures, surgical dental procedures, TM Joint surgery, biofeedback, phonophoresis, iontophoresis, transcutaneous electrical nerve stimulation (TENS), minimal electroneural stimulation (MENS), acupuncture, muscle trigger-point injections, hypnosis, psychological counseling, orthodontic and orthopedic appliances. Orthodontic, orthopedic, and prosthetic appliances may be swallowed and may have to be surgically removed. Inhaled appliances can lead to respiratory arrest and death. These occurrences are extremely rare and any appliances used will be designed to minimize this possibility.

Some TM Joint symptoms may temporarily become worse with treatment. Patients with long-standing arthritic joint disease or traumatic injury can demonstrate more severe symptoms during the initial stages of treatment.

Unusual Occurrences: As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root resorption, non-vital teeth, muscle spasms, ear and back problems, and numbness are all possible occurrences.
INFORMED CONSENT AGREEMENT (cont)

Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

Patient Signature _________________________________     Date __________________

Doctor Signature _________________________________     Date __________________

I hereby agree to pay Dr. Robert A. Finkel such sums as may be due and owing him for professional services rendered in the treatment of my injury or illness. I fully understand that I am directly and fully responsible to the doctor for all medical bills submitted by him for services rendered to me, and that this agreement is made solely for the doctor’s additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent upon any settlement, judgement or verdict by which I may eventually recover such a fee (In cases of accident, injury, or legal action). I understand that payment for all medical charges is my personal responsibility as my insurance company may disallow coverage for these disorders.

In the event this treatment is for illness arising from an accident or injury with attendant litigation, and there is any outstanding balance for treatment fees, I further agree that Dr. Finkel will be paid at the time of settlement, judgment, or verdict which may be paid to me or my attorney as a result of the above-mentioned injuries. I understand and agree that this in no way relieves me of any personal responsibility to pay Dr. Finkel for all medical charges.

In the event these charges are being submitted for payment to my medical, dental, or other insurance carrier, I am aware that each insurance carrier has its own policy regarding payment for TMJ/ Myofascial Pain Therapies and my insurance policy may not cover these medical charges. I am aware it is likely that my insurance company may disallow coverage for any or all of these charges and that I agree to be responsible for payment of them.

I understand that this office submits medical and dental charges to the appropriate insurance companies as a courtesy to me and that this does not relieve me of my responsibility for their payment. If/when such payment is declined by my insurance company, I will be responsible for payment; if not received from insurance company within 60 days.

Patient Signature _________________________________     Date __________________

Doctor Signature _________________________________     Date __________________
INFORMED CONSENT AGREEMENT (cont)

I, Undersigned (Patient or Legally Responsible Party), have read or have had read to me the contents of this form and do realize the risks and limitations involved and do authorize treatment to be rendered, and assume financial responsibility. It is also understood that any and all records, appliances, models, radiographs, video tapes, and photographs taken before, during, and after the examination and treatment shall remain the property of Robert A. Finkel, D.D.S., P.C.

Signature: ____________________________ Date: __________________
Witness: ______________________________ Date: __________________

I authorize Dr. Robert A. Finkel and Staff to furnish my attorney with such information, documents, and reports as he may request regarding my treatment.

Patient Signature: ____________________________ Date: __________________
Witness: ______________________________ Date: __________________

I authorize Dr. Robert A. Finkel and Staff to furnish my insurance company (ies) with such information, copies of documents, duplicates of x-rays and reports as it may request regarding my treatment. I understand that a reasonable fee may be charged for such reports and that all records, charts, models, and x-rays remain the property of Robert A. Finkel, D.D.S., P.C.

Patient Signature: ____________________________ Date: __________________
Witness: ______________________________ Date: __________________
Robert A. Finkel, D. D. S.
TMJ and Orofacial Pain Patient Questionnaire

Please Print with Blue Ball Point

Sex ____________________ Date of Birth ____________________ Age ____________________
Marital Status ______________ Height ________________ Weight ________________
Address __________________________________________________________________________

_________________________________________________________________________________

Phone ___________________________ Social Security No. __________________________
Occupation ___________________________ Employer _____________________________
Business Phone ___________________________ Employer Address ___________________________

Who may we thank for referring you? __________________________________________________
Address: ________________________________________________________________

Dental Insurance Carrier: ___________________________________________________________
Policy # ______________ Name of Insured _____________________________________________

Medical Insurance Carrier: _________________________________________________________
Policy # ______________ Name of Insured _____________________________________________

Automobile Insurance Carrier: _____________________________________________________
Policy # ______________ Name of Insured _____________________________________________

Auto Accident:   Y     N    Claim # ___________________________________________________
Name of insured: ___________________________________________ Date of Birth:______________
Address of Insured: _________________________________________________
Name of Adjuster: _____________________________________________________________

Insurance Notes: ________________________________________________________________

Spouse’s Name ____________________________________ Age __________ SS No. __________
Occupation ___________________________________________ Employer ______________________
Employer Address ___________________________________________ Phone __________________
In case of emergency notify ___________________________________________ Phone ________
Nearest relative not living with you ________________________________________________
Address ___________________________________________ Phone ________________________
Personal Physician ___________________________________________ Phone _________________
Address ___________________________________________ Date of Last Exam ________________
Personal Dentist ___________________________________________ Phone _________________
Address ___________________________________________ Date of Last Exam ________________
**Nature of Problem (s):**
Most Significant:  
Next Significant:  
Next Significant:  

Date of onset ________________________________   Area of Onset ________________________________

Did Symptoms follow any physical or emotional occurrences? ________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

What specialists have you seen for your pain?

<table>
<thead>
<tr>
<th>Specialist Name/ Address</th>
<th>Dates Examined</th>
<th>Treatments</th>
<th>Results</th>
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<tbody>
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</table>

What medications have you taken for your condition?  
______________________________________________________________________________________________
______________________________________________________________________________________________

What medications are you now taking for your condition?  
______________________________________________________________________________________________

What treatment/medication was most successful?  
______________________________________________________________________________________________

What treatment/medication was least successful?  
______________________________________________________________________________________________

Are you aware of anything that aggravates your condition?  
(stress, foods, alcohol, chewing, weather, etc.)  
______________________________________________________________________________________________

Are you aware of anything that helps relieve your pain?  
______________________________________________________________________________________________

How does your condition affect you?  
______________________________________________________________________________________________

Please circle the number which indicates severity of your pain:
No Pain-1-2-3-4-5-6-7-8-9-10- Severe Pain

Are you currently involved in or contemplating litigation related to your condition?  YES  NO
Have you ever had?

Trauma to the head, neck or face?  YES  NO  If yes, please explain:
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Are you being treated for any medical condition(s)?  YES  NO  
If yes, please explain and list physician treating condition:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Are you now taking any medications?  YES  NO  If yes, please explain:
Aspirin   Y   N   _______________________________________________________________________
Oral Contraceptives   Y   N   _______________________________________________________________________
Antibiotics   Y   N   _______________________________________________________________________
Other   ____________________________________________________________________________________________
Other   ____________________________________________________________________________________________
Other   ____________________________________________________________________________________________

Are you allergic to any drugs?  YES  NO  If yes, please explain:
Local Anesthetic   ___________________________________________________________________________________
Antibiotics   _______________________________________________________________________________________
Pain Killers   _______________________________________________________________________________________
Other   ____________________________________________________________________________________________
Other   ____________________________________________________________________________________________

Date and reason for last physical exam:   _________________________________________________________________

Has your health changed in the last year?  YES  NO  If yes, please explain:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________


## Current or Previous Medical Problem(s):
( Please circle correct answer and give date of last occurrence. )

| Problem                          | Y | N | Date | | Problem                          | Y | N | Date |
Do You Have:
Difficulty in swallowing?   Y   N
Soreness around face or neck?   Y   N
Stiff neck muscles?   Y   N
Grinding or clenching of teeth during the day?   Y   N
Grinding or clenching of teeth during the night?   Y   N
Popping or clicking in right jaw joint?   Y   N
Popping or clicking in left jaw joint?   Y   N
Difficulty in opening wide?   Y   N
Stiff jaw or sore teeth upon waking?   Y   N
Stiff jaw or sore teeth at end of day?   Y   N
Headaches?   Y   N
Easily tired jaw muscles?   Y   N
Ringing or buzzing in the ears?   Y   N
Pain on turning the head or moving the neck?   Y   N
Increased pain when reaching overhead?   Y   N
Numbness or tingling in hand and/or arm?   Y   N
Pain in hand and/or arm?   Y   N

Diet:
Do you have unusual reactions to any foods?   Y   N
Do any foods aggravate your condition?   Y   N
Do chewy foods (eg. Bagels) aggravate your condition?   Y   N
How many glasses of liquid do you drink daily?   Y   N
How many caffeine-containing drinks (coffee, tea, colas, etc.) do you consume daily?
What sugar-containing foods or drinks do you consume regularly?

Do you usually eat breakfast?

Sleep:
Do you awake with a morning headache?   Y   N
Do you have difficulty waking or feel drowsy during the morning?   Y   N
Do you feel fatigued through-out the day?   Y   N
Have you been told that you snore?   Y   N
Have you been told that you stop breathing and gasp for air while sleeping?   Y   N

Do you wake periodically during the night?   Y   N

Ear/Eye Symptoms:
R    L    NO
[ ]   [ ]   [ ] Pain in ear (Otalgia)    R    L    NO
[ ]   [ ]   [ ] Ringing in Ear (Tinnitus)    [ ]   [ ]   [ ] Vertigo (dizziness, lost balance)
[ ]   [ ]   [ ] Stiffness/ Fullness in ear    [ ]   [ ]   [ ] Eye Pain
[ ]   [ ]   [ ] Change in hearing    [ ]   [ ]   [ ] Vision changes

Describe your pain (underline all that apply)
Y   N   A. Stabbing/Sharp (Tissue)
Y   N   B. Shocking/ Piercing/Burning (Neural)
Y   N   C. Dull/ Aching (Myalgia/ Arthralgia)
Y   N   D. Spasming/ Tightening/ Cramping (Muscle)
Y   N   E. Pulsating (Vascular)
Y   N   F. Other
Frequency of Pain: (How Often?)
Onset of Pain:  [ ] Gradual  [ ] Abrupt
Duration of Pain:  [ ] Gradual  [ ] Abrupt
Cessation of Pain:  [ ] Gradual  [ ] Abrupt

Location of Pain (Subjective)  (Grade 1-10) Please Shade in Red
R  L  NO
__  __  [  ] Top of Head
__  __  [  ] Back of Head
__  __  [  ] Side of Head
__  __  [  ] In Ears
__  __  [  ] Front of Ears
__  __  [  ] In Eyes
__  __  [  ] Above Eyes
__  __  [  ] Behind Eyes
__  __  [  ] Neck
__  __  [  ] Shoulder/ Arm
__  __  [  ] Back
__  __  [  ] Teeth

Daily Pattern of Pain: If yes, please explain:
Severe upon waking?  Y  N ______________________________________________________________________
Severe at nights?  Y  N ______________________________________________________________________
Increases as day goes on?  Y  N ______________________________________________________________________
Decreases as day goes on?  Y  N ______________________________________________________________________
Period of greatest intensity? ______________________________________________________________________
Status of pain:  [  ] Increasing  [  ] Decreasing  [  ] Unchanged ______________________________________

Daily Habits:
[  ] Phone Cradling  [  ] Pipe/ cigar/ cigarette  [  ] Gum Chewing
[  ] Shoulder Bag  [  ] Heavy lifting  [  ] Computer Use

Oral Habits:
Clenching:  [  ] Nightly  [  ] Daily  [  ] None ______________________________________________________________________
Grinding:  [  ] Nightly  [  ] Daily  [  ] None ______________________________________________________________________
Chewing/ Holding Items in Mouth:  Y  N ______________________________________________________________________
Chewing Gum or Tobacco:  Y  N ______________________________________________________________________

Have you had sinus infections/ problems?  Y  N ______________________________________________________________________
Do you have a sinus infection/ problem now?  Y  N ______________________________________________________________________
Do you play any musical instruments?  Y  N ______________________________________________________________________
Do any areas become painful with light touch?  Y  N ______________________________________________________________________
Do any areas become painful upon swallowing?  Y  N ______________________________________________________________________
Were you ever treated for a “bad bite”?  Y  N ______________________________________________________________________

Has your bite changed in the last five years?  Y  N ______________________________________________________________________
Have your jaw joints changed in the last five years?  Y  N ______________________________________________________________________
 (popping, clicking, locking, pain?)
Have your teeth changed in the last five years?  Y  N ______________________________________________________________________
 (thinner, breaking, chipping, shorter, looser, more spacing?)

Anything Else?  Y  N ______________________________________________________________________
Please explain: ____________________________________________________________________________________
1. Chief Complaints  1. ___________________________________________________________________________
   2. ___________________________________________________________________________
   3. ___________________________________________________________________________
   4. ___________________________________________________________________________

2. Pain:  Descriptors: ______________________________________________________________
          Frequency: ___________________________________________________________________
          Duration: _____________________________________________________________________
          Better/Worse __________________________________________________________________

3. TMJ
   Opening Click  R ___ yes ___ L no ___
   Closing Click  R ___ yes ___ L no ___
   Opening Crepitus  R ___ yes ___ L no ___
   Closing Crepitus  R ___ yes ___ L no ___
   Pain Laterally  R ___ yes ___ L no ___
   Pain via EAM  R ___ yes ___ L no ___
   Pain via EAM on Closure  R ___ yes ___ L no ___
   Pain on Loading  R ___ yes ___ L no ___
   Pain on Opening  R ___ yes ___ L no ___
   Pain in Closure  R ___ yes ___ L no ___

Joint Auscultation: ________________________________________________________________
Clicking eliminated on repositioning? ______________________________________________
Able to recapture/hold? __________________________________________________________
Other: __________________________________________________________________________

4. Palpation of Muscles:  Pain or Tenderness
   1. Temporalis
      a: Anterior  R ___ yes ___ L no ___
      b: Middle  R ___ yes ___ L no ___
      c: Posterior  R ___ yes ___ L no ___
   2. Masseter
      a. Anterior  R ___ yes ___ L no ___
      b. Posterior  R ___ yes ___ L no ___
   3. Coronoid  R ___ yes ___ L no ___
   4. Lateral Pterygoid  R ___ yes ___ L no ___
   5. Medial Pterygoid  R ___ yes ___ L no ___
   6. Sternochleidomastoid
      a: Sternal  R ___ yes ___ L no ___
      b: Clavicular  R ___ yes ___ L no ___
   7. Scaleneus  R ___ yes ___ L no ___
   8. Digastrics  R ___ yes ___ L no ___
   9. Posterior Cervicals  R ___ yes ___ L no ___
  10. Trapezius (TPI)  R ___ yes ___ L no ___
  11. Sub-Occipitals  R ___ yes ___ L no ___
  12. Splenius Capitus  R ___ yes ___ L no ___
  13. Supra-Hyoids  R ___ yes ___ L no ___

Pain Duplication: ________________________________________________________________
Trigger Points: ____________________  Referred to: ________________________________
__________________________  __________________________
__________________________  __________________________

14
5. Occlusal Flags:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Right</th>
<th>Yes</th>
<th>Left</th>
<th>No</th>
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<tbody>
<tr>
<td>Loss of Posterior support</td>
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<tr>
<td>Deep bite/overclosure</td>
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<tr>
<td>Wear facets</td>
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<tr>
<td>Incisal Wear/Thinning/Chipping</td>
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<tr>
<td>Posterior cusp wear</td>
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<tr>
<td>Anterior crowding</td>
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<tr>
<td>Incisors locked in</td>
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<tr>
<td>Tooth/filling fracture</td>
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<td>Fremitus</td>
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<tr>
<td>Linguoversion Max. Anteriors</td>
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Stable Occlusion: _________________________________
Occlusal Interferences: ___________________________
Shimabashi #: ____________________________
Hx Ortho: ______________________________________

6. a: Headache/ Migraines:_________________________

b: Neckache: ______________________________________

c: Ear symptoms: _________________________________

d: Eye symptoms: _________________________________

e: Mouth/Throat/Jaw: ______________________________

7. MISC:

a: Tongue thrust/Swallow: _________________________

b: Ear: __________________________________________

b: Sinus: ________________________________________

c: Sinus: ________________________________________

d: Salivary glands: ______________________________

e: Clench/Grind: _________________________________

f: Stress: ______________________________________

g: Head Posture: _________________________________

h: Back Posture: _________________________________

i: Neural Changes: ______________________________

ej: Cervical Probs/ R.O.M.: _______________________

k: Other: _______________________________________

8. ORAL:

a: Endo/ Pulpitis: ______________________________

b: Perio/ Gingival: _____________________________

c: Cracked Tooth: ______________________________

d: Occlusal Trauma: _____________________________

e: Caries: ______________________________________

f: Anteriors: Worn, Chipped, Thinned, Locked: ________________

9. Sleep Problems: ______________________________

10. Habits (pg. 12): ______________________________

11. Panoramic: _________________________________

Trans-Cranials: ________________________________

Tomograms: ___________________________________

Craniomandibular Scan: _________________________

12. Neural:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Right</th>
<th>Yes</th>
<th>Left</th>
<th>No</th>
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<tbody>
<tr>
<td>I Olfactory- smells</td>
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<tr>
<td>II Optic- visual/color/pupils</td>
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<td>III Oculomotor- lift/blink</td>
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<tr>
<td>IV Trochlear – eye rotation</td>
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<td>V Trigeminal- touch 1,2,3,</td>
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<td>VI Abducens- eyes R/L</td>
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<td>VII Facial- frown, grimace, smile</td>
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<td>VIII Auditory- hearing/balance</td>
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<tr>
<td>IX Glossopharyngeal-tongue/palate/speech</td>
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<td>X Vagus-tongue/palate/speech</td>
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<tr>
<td>XI Spinal Accessory-SCM/shrug</td>
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<td>XII Hypoglossal-tongue movement</td>
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</tbody>
</table>
Review of Systems:

1. Neural:
   - a: Neuralgia
   - b: Causalgia (reflexive diystrophy)
   - c: CNS Lesions
   - d: Infect/viral
   - e: Neural/Cranial

2. Vascular:

3. TMJ:
   - a: Rheumatic
   - b: Osteoarthritic
   - c: Inflammatory (capsular/retro-disc)
   - d: Disk malpositioned (Int. derang)

4. Myofascial:
   - a: Primary muscle
   - b: Referred muscle
   - c: Postural

5. Dento-alveolar:
   - a: Endodontic
   - b: Periodontal
   - c: Cracked tooth
   - d: Occ. Trauma

6. Lesions:
   - a: Cyst
   - b: Abcess
   - c: Ratner Cavities
   - d: Neoplasm

7. Trauma/Fracture

8. Psychogenic

9. Sleep Disorder

10. Myofunctional

11. ENT

12. Cervical Spine:
   - a: Neuropathy
   - b: Joint
   - c: Myofascial

13. Cranial

14. Habits

15. Other
**SUMMARY OF FINDINGS:**

1. **Chief Complaints:**
   a: 
   b: 
   c: 
   d: 

2. **Patient Concerns:**
   a: 
   b: 
   c: 

3. **Subjective:**
   a: 
   b: 
   c: 
   d: 

4. **Medical Hx:**
   a: 
   b: 
   c: 

5. **Objective:**
   a: 
   b: 
   c: 
   d: 
   e: 

6. **Comments:**
   a: 
   b: 
   c: 

7. **Diagnosis:**
   a: 
   b: 
   c: 
   d: 

8. **Recommended Tx:**
   a: 
   b: 
   c: 
   d: 
   e: 
   f: 
   g: 
   i: 
**DIAGNOSIS:**

<table>
<thead>
<tr>
<th>TMI:</th>
<th>Insurance</th>
<th>Use</th>
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</thead>
<tbody>
<tr>
<td>___ TMJ Disorder</td>
<td>524.6</td>
<td></td>
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<tr>
<td>___ Pain in TMJ</td>
<td>524.62</td>
<td></td>
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<tr>
<td>___ Degenerative Arthritis</td>
<td>715.9</td>
<td></td>
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<tr>
<td>___ Osteoarthritis</td>
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<tr>
<td>___ Rheumatoid Arthritis</td>
<td>714.0</td>
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<tr>
<td>___ TMJ Arthropathy – Traumatic</td>
<td>716.1</td>
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<tr>
<td>___ TMJ Dislocation – Closed Lock</td>
<td>830.0</td>
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<tr>
<td>___ TMJ Dislocation – Open Lock</td>
<td>830.1</td>
<td></td>
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<tr>
<td>___ Articular Cartilage Dislocation (Non-recurrent)</td>
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<td></td>
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<tr>
<td>___ Articular Cartilage Dislocation (Recurrent)</td>
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<tr>
<td>___ Sprain/Strain of Ligaments/Tendons</td>
<td>848.1</td>
<td></td>
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<tr>
<td>___ Ankylosis of TMJ</td>
<td>524.61</td>
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<tr>
<td>___ Capsulitis of TMJ</td>
<td>726.9</td>
<td></td>
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<tr>
<td>___ Benign Neoplasm (Condylar Chondroma)</td>
<td>213.1</td>
<td></td>
</tr>
<tr>
<td>___ Trauma to TMJ/Head/Neck</td>
<td>959.0</td>
<td></td>
</tr>
</tbody>
</table>

| MYOFASCIAL: | |
| ___ Muscle Spasm | 728.85 |    |
| ___ Masseter/Parotid Hypertrophy | 527.1 |    |
| ___ Cervicalgia (Neck Pain) | 723.1 |    |
| ___ Myalgia/Myositis/Myofascitis | 729.1 |    |

| GENERAL: | |
| ___ Anom. Relat. Bt. Mandib. and Cranial Base | 524.1 |    |
| ___ Cranio-Cervical Stress Arthropathy | 716.18 |    |
| ___ Muscle Ligament & Fascia (Eagle’s Syndrome) | 728.89 |    |
| ___ Pain in Jaw | 524.62 |    |

| NEURAL: | |
| ___ Trigeminal Neuralgia | 350.1 |    |
| ___ Atypical Facial Pain | 350.2 |    |
| ___ Facial Nerve (VII) Disorder |    |    |
| ___ Facial Neuralgia/Neuritis | 729.2 |    |
| ___ Cephalgia (Headache)/Facial Pain | 784.0 |    |
| ___ Trigeminal Neuralgia (Bell’s Palsy) | 351.0 |    |
| ___ Orofacial Dyskinesia | 333.82 |    |
| ___ Spasmodic Torticollis | 333.83 |    |

| EAR: | |
| ___ Vertigo | 780.4 |    |
| ___ Tinnitus | 388.3 |    |
| ___ Otalgia | 388.7 |    |

| OTHER: | |
| ___ Bruxism- (unspec’d) | 728.9 |    |
| ___ Tension Headaches | 307.81 |    |
| ___ Bruxism/Psychophysiological Mal-Fn, Stress- Induced | 306.8 |    |
| ___ Disorder of Autonomic Nervous System (Reflex Sympathetic Dystrophy) | 337.9 |    |
RECOMMENDED TREATMENT:

___  1. Eliminate caffeine and sugar from diet.
___  2. Eliminate Nutra-sweet (aspartame) from diet.
___  3. Drink 6-8 glasses of liquid a day.
___  4. Use blue dots: “lips together, teeth apart, muscles relaxed, posture straight”.
___  5. L-Tryptophan: 500 mg tablets (from health food store).
   Dosage: ____________________________________________________________
___  6. Cervical Pillow: Type________________________________________________________
___  7. Avoid hard foods; minimize chewing; duration:______________________________
___  8. Maintain soft/liquid diet: duration __________________________________________
___  9. Avoid wide opening, stretching, yawning ____________________________
___ 10. Opening/ Closing exercises (static: isometric) __________________________

___ 11. Opening/ Closing exercises (active: Isotonic) _____________________________

___ 12. Ice; Heat; Ice/Heat: ____________________________________________________

___ 13. Shower/ Stretch Therapy ______________________

___ 14. Walking/ Exercise __________________________

___ 15. Neuro-Mucular Release _________________________________________________
   Area: a. ___________________________ c. ___________________________
   b. ___________________________ d. ___________________________
   Daily Repetitions: _________________________________________________________

___ 16. Hours of sleep per night: __________________________

___ 17. Splint wear: a. Full time __________________________
   b. Intermittent __________________________
   c. Other __________________________

___ 18. Physiotherapy: a. TENS (pulsing) __________________________________________
   b. Vapocoolant __________________________
   c. __________________________________
   d. __________________________________

___ 19. Physical Therapy: ______________________________________________________

___ 20. Phase I Therapy: _______________________________________________________

___ 21. Phase II Therapy: _______________________________________________________

___ 22. Consultations: __________________________________________________________
   a. __________________________________
   b. __________________________________
   c. __________________________________

___ 23. Medications: ____________________________________________________________
   a. __________________________________
   b. __________________________________

___ 24. Other: _________________________________________________________________
___ 25. Other: _________________________________________________________________
___ 26. Other: _________________________________________________________________
CONSULTATION

Chief Concern:

1. Diagnosis:
   A. _______________________________________________________
   B. _______________________________________________________
   C. _______________________________________________________
   D. _______________________________________________________

2. Probability of Internal Joint Damage:________________________________________________________

3. Muscle Component/Involvement:_____________________________________________________________

4. Goal of Treatment:
   A. Joint _______________________________________________________
   B. Muscle _______________________________________________________
   C. Function _______________________________________________________
   D. Other _______________________________________________________

5. Projected Treatments:
   A. _______________________________________________________
   B. _______________________________________________________
   C. _______________________________________________________
   D. _______________________________________________________
   E. _______________________________________________________
   F. _______________________________________________________

6. Prognosis: (Limitations)
   A. _______________________________________________________
   B. _______________________________________________________
   C. _______________________________________________________
   D. _______________________________________________________

7. Alternatives:
   A. _______________________________________________________
   B. _______________________________________________________
   C. _______________________________________________________
   D. _______________________________________________________

8. Probable Treatment Duration:
   A. Phase I _______________________________________________________
   B. Phase II _______________________________________________________

9. Probable Treatment Fee:
   A. Phase I _______________________________________________________
   B. Phase II _______________________________________________________


CONSULTATION (cont)

10. Phase I (Splint, Orthotic, or MORA) Therapy is a diagnostic procedure to attempt to establish proper function of the jaws, muscles, and joints, and determine the proper jaw position to maintain the proper function. During Phase I we attempt to make the joints and muscles comfortable and pain free; multiple visits and adjustments are required as joint/muscles inflammation decreases and muscle spasm subsides. Procedures may involve bite adjustments, TENS therapy, trigger point (pain) injections, etc; at separate fees. Duration and cost of Phase I therapy is usually 6-18 months and in the range of $2800 to $3800.

11. Phase II Therapy is projected to stabilize and hold the jaws at the position determined by Phase I; cost and specific procedures can be determined only if and when Phase I has been completed and the needs of your jaw position and bite support evaluated. Phase II therapies are separate procedures with separate fees from Phase I treatments and may include any of the following:

   a. No further treatment (ie: No Phase II Therapy Needed).
   b. Night time wear only of the appliance.
   c. Dietary and Habit modification.
   d. Bite (occlusal) adjustments.
   e. Crowns and bridges to establish the bite and/or replace missing teeth.
   f. Dentures/Partial dentures to establish the bite and replace missing teeth.
   g. Orthodontics (braces)
   h. A long term (overlay) appliance
   i. Surgical correction (In certain limited cases)

   Phase II fees can be established at the completion of Phase I Therapy.

12. It is understood, as with any medical treatments, that guarantees of success cannot be given: often this problem can be successfully managed but not cured. Failure to follow recommended treatment will certainly hamper the results and decrease the possibility of a successful outcome of therapy.

Patient’s Signature____________________________________    Date______________

Doctor’s Signature____________________________________    Date______________