Highlands Ranch Orthodontics, P.C.
For Children and Adults

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Excellence in orthodontic care

Cranio-Mandibular Function Questionnaire

Name:_____ Date:_____

Please list your specific complaints. List them in order, starting with the most important to the least important.

1._____

2._____

3._____

4._____

When did you first notice the problems?

_____

Do you feel that the onsets of your problems are associated with any specific event?

_____

From the following list please check the treatments you have received for this problem:

medication	[ ]	physical therapy	[ ]	orthodontics	[ ]	soft diet	[ ]
counseling	[ ]	surgery	[ ]	bite splint	[ ]	heat/cold tx	[ ]
other	[ ]	occlusal adjustment	[ ]				

Which of the following have you consulted regarding this problem?

general dentist	[ ]	psychiatrist	[ ]	physical therapist	[ ]	orthodontist	[ ]
psychologists	[ ]	family physician	[ ]	oral surgeon	[ ]	osteopath	[ ]
ear, nose, throat	[ ]	neurologist	[ ]	internist	[ ]	other	[ ]

Does nervous tension seem to affect this problem? YES [ ] / NO [ ]

Explain:_____

Have you had problems with other joints? YES [ ] / NO [ ]

Explain:_____

Have you had any recent dental treatment? YES [ ] / NO [ ]

When?_____ Where?_____

What was done?

_____

Have you had orthodontic treatment? YES [ ] / NO [ ]

When? Where?

Have you had x-rays taken for this problem? YES [ ] / NO [ ]

Explain:

_____

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Please list the previous treatments in order with the approximate dates, the provider and the results.

Treatment Dates Provider

1:_____

Results:

_____

2:_____

Results:

_____

3:_____

Results:

_____

Does your jaw problem interfere with your day-to-day activities? YES [ ] / NO [ ]

Explain:

_____

JOINT NOISES:

Do you have clicking, popping or grating noise:

in your right joint YES [ ] / NO [ ]

in your left joint YES [ ] / NO [ ]

When did you first notice the noise?_____

Has the noise recently become more pronounced? YES [ ] / NO [ ]

When?_____

Has the noise ever disappeared? YES [ ] / NO [ ]

Has the noise ever changed? YES [ ] / NO [ ]

Explain:

_____

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JAW LOCKING:

Has your mouth ever locked open so you were unable to close it? YES [ ] / NO [ ]

Explain:

_____

Have you ever had trouble opening your mouth wide? YES [ ] / NO [ ]

Explain:

_____

How often does this happen? _____

What do you do when this happens?_____

Has the frequency increased recently? YES [ ] / NO [ ]

Is it painful? YES [ ] / NO [ ]

JOINT PAIN:

Do you have pain around the:

right joint? YES [ ] / NO [ ]

left joint? YES [ ] / NO [ ]

When did you first notice the pain?_____

Has the pain recently become more pronounced? YES [ ] / NO [ ]

Is the pain more severe:

	right	left		right	left
mornings	_____	_____	at meals	_____	_____
evenings	_____	_____	no specific time	_____	_____

Is the pain:

	right	left		right	left
dull	_____	_____	continuous	_____	_____
stabbing	_____	_____	intermittent	_____	_____
throbbing	_____	_____	other	_____	_____

Does anything make the pain worse?_____

Does anything make the pain better?_____

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HEAD ACHES/SHOULDER PAIN:

Do you have frequent headaches or neckaches? YES [ ] / NO [ ]

Where are they located?_____

How often do you have these headaches?_____

When do the headaches usually begin?_____

How do you control the pain?_____

Is it effective? YES [ ] / NO [ ]

Have you been told you have migraine headaches? YES [ ] / NO [ ]

LIFESTYLE:

Have there been any recent changes in your lifestyle such as a change in marital status, childbirth, change in employment, death in a family or other stressful event? YES [ ] / NO [ ]

Do you feel under a lot of stress? YES [ ] / NO [ ]

How many caffeine beverages do you consume daily?_____

Do you work more than 40 hours per week? YES [ ] / NO [ ]

TRAUMA:

Have you ever received a severe blow to the head? If so, when? _____

Have you ever received a blow to the face? If so, when? _____

Have you ever received a blow to the jaw? If so, when? _____

Have you ever had a whiplash neck injury? If so, when? _____

Have you ever broken your jaw? If so, when? _____