TEMPOROMANDIBULAR DISORDER (TMD)
INITIAL EVALUATION FORM

Caroline Feig, DPT, GCFP | Please complete what feels relevant to you. You may leave any optional item blank.

Name: _____ Date: _____

Date of Birth: _____ Referring Provider: _____

1 REASON FOR VISIT

What brings you in for TMD / jaw physical therapy?

When did your symptoms begin, and was there anything that seemed to coincide with the onset?

Which concerns are you experiencing? Check all that apply.

- ☐ Jaw pain
- ☐ Jaw clicking/popping
- ☐ Jaw locking
- ☐ Difficulty closing the mouth
- ☐ Ear pain/fullness
- ☐ Headaches
- ☐ Tooth pain/sensitivity
- ☐ Dizziness
- ☐ Facial pain
- ☐ Jaw grinding/grating
- ☐ Limited mouth opening
- ☐ Pain or difficulty chewing
- ☐ Ringing in the ears
- ☐ Neck pain/stiffness
- ☐ Temple pain
- ☐ Other: _____

2 JAW SYMPTOMS & FUNCTION

Where do you feel your symptoms? Check all that apply.

- ☐ Right jaw
- ☐ Left jaw
- ☐ Both sides
- ☐ In front of the ear
- ☐ Cheek/face
- ☐ Temple
- ☐ Inside the mouth
- ☐ Neck
- ☐ Other: _____

Do you hear or feel clicking, popping, grinding, or other noises in the jaw?

☐ Yes ☐ No

If yes, please describe when it occurs (opening, closing, chewing, yawning, etc.).

Has your jaw ever locked or become stuck open or closed?

☐ Yes ☐ No

Do you have difficulty opening your mouth wide?

☐ Yes ☐ No

Which activities aggravate your symptoms? Check all that apply.

- ☐ Chewing
- ☐ Yawning
- ☐ Singing
- ☐ Opening wide
- ☐ Stress
- ☐ Biting
- ☐ Talking
- ☐ Dental procedures
- ☐ Eating hard/chewy foods
- ☐ Exercise

☐ Other: _____

3 PAIN & ASSOCIATED SYMPTOMS

How would you describe the sensation? Check all that apply.

☐ Aching
☐ Pressure
☐ Fatigue
☐ Sharp
☐ Tightness
☐ Tenderness
☐ Burning
☐ Throbbing
☐ Other: _____

Do you experience headaches?

☐ Yes ☐ No

If yes, where are they usually located and how often do they occur?

Do you experience neck, shoulder, upper-back, or ribcage discomfort or stiffness?

☐ Yes ☐ No

If yes, please describe.

Do you experience ear symptoms such as fullness, pain, ringing, or changes in hearing?

☐ Yes ☐ No

4 HABITS & DAILY FACTORS

Do any of the following apply to you? Check all that apply.

☐ Clenching during the day
☐ Chewing gum frequently
☐ Chewing pens/pencils
☐ Sleeping on stomach/face
☐ Playing a wind instrument
☐ Other: _____
☐ Grinding at night
☐ Nail biting
☐ Resting chin on hand
☐ Frequent hard or chewy foods
☐ Prolonged computer/phone use

Do you notice that stress, concentration, exercise, or sleep affects your jaw symptoms?

☐ Yes ☐ No

If yes, please describe what you notice.

5 DENTAL & MEDICAL HISTORY

Have you had any recent or significant dental work, orthodontics, oral surgery, or changes to your bite?

☐ Yes ☐ No

If yes, please describe.

Do you use a night guard, splint, retainer, CPAP, oral appliance, or other dental device?

☐ Yes ☐ No

If yes, what do you use and how often?

Have you had an injury or trauma involving the jaw, face, head, or neck?

☐ Yes ☐ No

If yes, please describe.

6 SLEEP & AIRWAY

Do you have any concerns related to sleep or breathing? Check all that apply.

☐ Snoring
☐ Dry mouth on waking
☐ Daytime fatigue
☐ Use of CPAP
☐ No known concerns
☐ Mouth breathing
☐ Poor-quality sleep
☐ Diagnosed sleep apnea
☐ Use of oral sleep appliance
☐ Other: _____

Is there anything else about your sleep, breathing, or airway that you think may be relevant? (optional)

7 WHOLE-BODY FACTORS

Have you noticed any relationship between your jaw symptoms and your posture, breathing, neck movement, exercise, or other areas of your body?

Are there activities, positions, or movements that make you feel better?

8 GOALS & ADDITIONAL INFORMATION

What would you most like to be able to do more comfortably or confidently as a result of treatment?

Is there anything else you would like me to know before we meet?