KENNETH C. BARNEY, D.D.S.
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ARTISTRY • INTEGRITY • PASSION

101 NORTH MARY STREET
HEDGESVILLE, WV. 25427

TMJ/TMD SCREENING QUESTIONNAIRE

Referred by:____Date:____________________

Name:____Date of Birth:____________________

Address:____

City:_____________________________________State:_________________Zip:_______________

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by placing an " X " in the appropriate areas. (L = Left; R = Right)

a. Pain in the jaw _____ L R_____

b. Pain in the ear _____L R____

c. Pain around the eyes _____L R_____

d. Pain in the lower jaw _____L R_____

f. Pain in the neck _____L R_____

g. Pain in the shoulder _____L R_____

h. Pain in the forehead _____L R_____

i. Pain in the temples _____L R_____

j. Pain in facial muscles _____L R_____

k. Grating sound in joint _____L R_____

l. Subjective hearing loss _____L R_____

m. Clicking, snapping or popping sound in joint. Most descriptive word ______________
(if present, is it in) _____L R_____

n. Dizziness *(Vertigo)* _____Yes No_____

o. Upset stomach-nausea _____Yes No_____

p. Ringing sound in ears _____L R_____

q. Headache _____Yes No_____

r. Fullness, pressure in ear _____L R_______

s. Pain in tongue _____Yes No______

t. Partial inability to open mouth ____Yes No ____
If yes, is it (1) Constant ☐
(2) Sporadic ☐

u. Difficulty Chewing _____ Yes No_____

v. Difficulty swallowing _____Yes No______

w. Loud snoring _____Yes No______

x. Constantly tired _____Yes No______

y. Mouth to breathe at night _____Yes No______

z. Awaken with dry mouth _____Yes No______
If yes, (1) Frequently ☐
(2) Rarely ☐
(3) Never ☐

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1. Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for this or related problems. Write on back of sheet if necessary.

   Date:________________Doctor:__________________________Location:_________________________

   Brief summary:____

   ____

   Date:________________Doctor:__________________________Location:_________________________

   Brief summary:____

   ____

   Date:________________Doctor:__________________________Location:_________________________

   Brief summary:____

   ____

   Date:________________Doctor:__________________________Location:_________________________

   Brief summary:____

   ____

2. Please write in any other pertinent information that has not been covered previously. Write on back of sheet if necessary.

   ____

   ____

   ____

   ____

   ____

   ____

3. Are you in litigation or are you planning litigation? _____Yes _____No

   If so, please explain____

   ____

   ____

   ____

Patient's Signature:____Date:______________________