

Initial TMD Examination Form

Patient Name:

Date:

TMD Assistant:

Patient Interview

- | | | |
|---|--|---|
| <input type="checkbox"/> temporal headaches | <input type="checkbox"/> occipital headaches | <input type="checkbox"/> wrap around |
| <input type="checkbox"/> headaches - daily | <input type="checkbox"/> headaches - weekly | <input type="checkbox"/> pre-menstrual |
| <input type="checkbox"/> nocturnal headaches | <input type="checkbox"/> cheek pain | <input type="checkbox"/> facial pain |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> back pain | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> clicking and popping (R) (L) | <input type="checkbox"/> grinding/Crepitus (R) (L) | <input type="checkbox"/> aware of limited opening |
| <input type="checkbox"/> ringing in the ears (R) (L) | <input type="checkbox"/> decreased hearing (R) (L) | <input type="checkbox"/> dizziness/vertigo |
| <input type="checkbox"/> hot and cold sensitivity | <input type="checkbox"/> tooth pain | |
| <input type="checkbox"/> cold all the time | <input type="checkbox"/> dry skin | <input type="checkbox"/> brittle hair |
| <input type="checkbox"/> finger tips tingle (R) (L) | <input type="checkbox"/> panic attacks | <input type="checkbox"/> tunnel vision |
| <input type="checkbox"/> abdominal fat storage | <input type="checkbox"/> masseter/facial hypertrophy | <input type="checkbox"/> dry mouth |
| <input type="checkbox"/> open mouth breathing | <input type="checkbox"/> previous accidents | <input type="checkbox"/> medications |

Pulse _____ BPM Temperature _____ F _____ / _____ BP Respiration _____ BPM

Chief Complaint:

Radiographic

- | | | | |
|---|--------------------------------|---|---------|
| <input type="checkbox"/> condylar flattening | (R) (L) | <input type="checkbox"/> condylar bird beaking | (R) (L) |
| <input type="checkbox"/> mandibular inferior board notching | (R) (L) | <input type="checkbox"/> mandibular angle irregularity | (R) (L) |
| <input type="checkbox"/> nasal turbinate hypertrophy | (R) (L) | | |
| <input type="checkbox"/> sinus polyps | (R) (L) | <input type="checkbox"/> sinus turbidity | (R) (L) |
| <input type="checkbox"/> occlusal wear - flattening | | <input type="checkbox"/> multiple root canals | (R) (L) |
| <input type="checkbox"/> mandibular torii | (R) (L) | <input type="checkbox"/> enlarged periodontal ligaments | |
| <input type="checkbox"/> condylar positioning | anterior middle superior | _____ | |

Screening Examination

- | | | | |
|---|---------|--|---------|
| <input type="checkbox"/> limited opening | | <input type="checkbox"/> deviation on opening | (R) (L) |
| <input type="checkbox"/> masseter origin tenderness | (R) (L) | <input type="checkbox"/> coronoid attachment tenderness | (R) (L) |
| <input type="checkbox"/> anterior temporalis tenderness | (R) (L) | <input type="checkbox"/> lateral pterygoid (sigmoid notch) | (R) (L) |
| <input type="checkbox"/> medial pterygoid | (R) (L) | | |
| <input type="checkbox"/> clicking and popping | (R) (L) | <input type="checkbox"/> TMJ Crepitus | (R) (L) |
| <input type="checkbox"/> open joint tenderness | (R) (L) | <input type="checkbox"/> closed pack joint | (R) (L) |
| <input type="checkbox"/> mandibular torus | (R) (L) | <input type="checkbox"/> mandibular exostosis | (R) (L) |
| <input type="checkbox"/> maxillary torus | (R) (L) | <input type="checkbox"/> maxillary exostosis | (R) (L) |
| <input type="checkbox"/> abfraction | | <input type="checkbox"/> localized gingivitis | |
| <input type="checkbox"/> tooth wear facets | | <input type="checkbox"/> cuspid flattening | |
| <input type="checkbox"/> masseter/facial hypertrophy | | | |

Range of Motion

Opening _____ mm Right Lateral _____ mm Left Lateral _____ mm
Head turn to right _____ degrees Head turn to left _____ degrees
Head side bend to right _____ degrees Head side bend to left _____ degrees

TMJ Auscultation

Right TMJ	Clicking	Popping	Early	Mid	Late	Crepitus	Yes	No
Left TMJ	Clicking	Popping	Early	Mid	Late	Crepitus	Yes	No

Peripheral Muscle Palpation

Sternocleidomastoid mastoid middle clavicle/sternum
suboccipitals Yes No Trapezius Yes No

Cranial Nerve Evaluation

1 <input type="checkbox"/> OK <input type="checkbox"/> AN	2 <input type="checkbox"/> OK <input type="checkbox"/> AN	3 <input type="checkbox"/> OK <input type="checkbox"/> AN	4 <input type="checkbox"/> OK <input type="checkbox"/> AN
5 <input type="checkbox"/> OK <input type="checkbox"/> AN	6 <input type="checkbox"/> OK <input type="checkbox"/> AN	7 <input type="checkbox"/> OK <input type="checkbox"/> AN	8 <input type="checkbox"/> OK <input type="checkbox"/> AN
9 <input type="checkbox"/> OK <input type="checkbox"/> AN	10 <input type="checkbox"/> OK <input type="checkbox"/> AN	11 <input type="checkbox"/> OK <input type="checkbox"/> AN	12 <input type="checkbox"/> OK <input type="checkbox"/> AN

Photographic Review

(R) (L) eye smaller than (R) (L)	Pogonion deviated to (R) (L)
(R) (L) ear lower than (R) (L)	Deep nasolabial fold (R) (L)
frontal/palpebral vertical folding <input type="checkbox"/> Yes <input type="checkbox"/> No	nostral size (S) (M) (L)
Forward Head Posture <input type="checkbox"/> Yes <input type="checkbox"/> No	Dowager's Hump <input type="checkbox"/> Yes <input type="checkbox"/> No
allergic shiners (R) (L)	Long Face Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No
Light skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Nasal crease <input type="checkbox"/> Yes <input type="checkbox"/> No
High Angle Profile <input type="checkbox"/> Yes <input type="checkbox"/> No	Frontal canting of inferior mandibular plane <input type="checkbox"/> Yes <input type="checkbox"/> No
Scalloped tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	

Initial Differential Diagnosis

<input type="checkbox"/> bruxism	<input type="checkbox"/> localized TMJ arthritis (R) (L)
<input type="checkbox"/> posterior dislocated condyle (R) (L)	<input type="checkbox"/> myositis <input type="checkbox"/> myalgia
<input type="checkbox"/> myofascial pain dysfunction syndrome	<input type="checkbox"/> temporal tendonitis <input type="checkbox"/> earnest syndrome
<input type="checkbox"/> hyoid bone syndrome	<input type="checkbox"/> occipital neuralgia lessor / greater
<input type="checkbox"/> Intracapsular Disorder	
<input type="checkbox"/> Anterior Displaced Disc with reduction (R) (L)	
<input type="checkbox"/> Anterior Displaced Disc without reduction (R) (L)	
<input type="checkbox"/> Disc perforation (R) (L)	
<input type="checkbox"/> trigeminal neuralgia <input type="checkbox"/> atypical trigeminal neuralgia <input type="checkbox"/> fibromyalgia	
<input type="checkbox"/> neuralgia inducing cavitational osteonecrosis	

Referrals

- | | | |
|--|---|--|
| <input type="checkbox"/> MD Generalist | <input type="checkbox"/> Allergist MD | <input type="checkbox"/> ENT MD |
| <input type="checkbox"/> MD Endocrinologist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Sleep MD | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Nutritional Counselor | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Rheumatologist |

Patient Education

- Soft Guard and Six Week Program
- Mandibular Orthopedic Repositioning Appliance
- Estimate of Phase I costs provided to the patient
- Review of possible Phase II treatment that may be necessary
- TMD Web Reference Sheet
- Allergy Self Help Book

TMD Treatment Protocol

- _____ Pain Release Splint
- _____ Nutrition Counseling
- _____ TMD Exercises
- _____ Trigger Point Injections
- _____ Neuromuscular Massage
- _____ Physical Therapy
- _____ Diagnostic Anaesthetic Injections
- _____ Mandibular Orthopedic Repositioning Appliance
- _____ Thyroid Evaluation
- _____ Insulin Evaluation hyperinsulinism/diabetes

Notes: