Steven R. Schnoll, D.D.S.

Adult and Child Dentistry / TMJ

Symptom Questionnaire - Initial

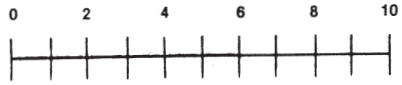
NAME _____ DATE _____

	Yes	On Occasion	No	
1	☐	☐	☐	Headaches - What part of your head? _____
2	☐	☐	☐	Dizziness or lightheadedness
3	☐	☐	☐	Ringing, buzzing or other sounds in the ears
4	☐	☐	☐	A feeling of fullness in the ears or sinuses
5	☐	☐	☐	Numbness or tingling of the fingertips
6	☐	☐	☐	Backaches - Upper? Lower?
7	☐	☐	☐	Neckaches
8	☐	☐	☐	Pain in opening or closing your mouth
9	☐	☐	☐	Clicking/popping sounds from your jaw joints
10	☐	☐	☐	Jaw locks when opening or closing
11	☐	☐	☐	Pain in the jaw joint - Dull? Sharp?
12	☐	☐	☐	Pain in the facial muscles
13	☐	☐	☐	Pain in: Chewing? Swallowing?
14	☐	☐	☐	Pain in the upper or lower teeth
15	☐	☐	☐	Easily fatigued or tired
16	☐	☐	☐	Throat problems (sore, tight, etc.)
17	☐	☐	☐	Difficulty in concentrating
18	☐	☐	☐	Inability to fully open your mouth as before
19	☐	☐	☐	Pain in the eye or visual problems

Other _____

Pain in Jaw / Face

NONE SEVERE



Pain in rest of body

MAIN PROBLEM: _____

REFERRING PERSON:

Name _____

Address _____

City _____ Zip _____

CURRENT DENTIST:

Name _____

Address _____

City _____ Zip _____

OTHER DOCTORS SEEN REGARDING THESE PROBLEMS:

Name _____

Address _____

City _____ Zip _____

Name _____

Address _____

City _____ Zip _____

Name _____

Address _____

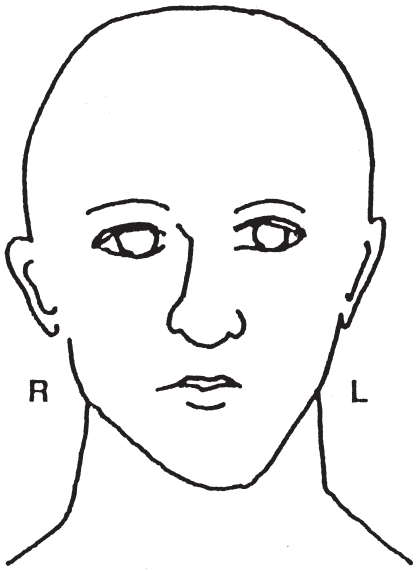
City _____ Zip _____

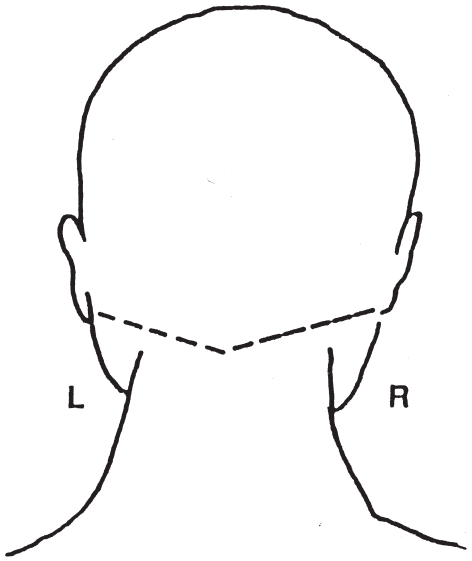
Name _____

Address _____

City _____ Zip _____

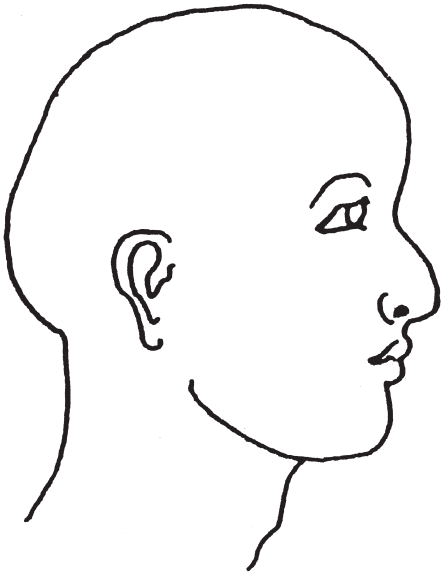
** Please complete diagram on back page



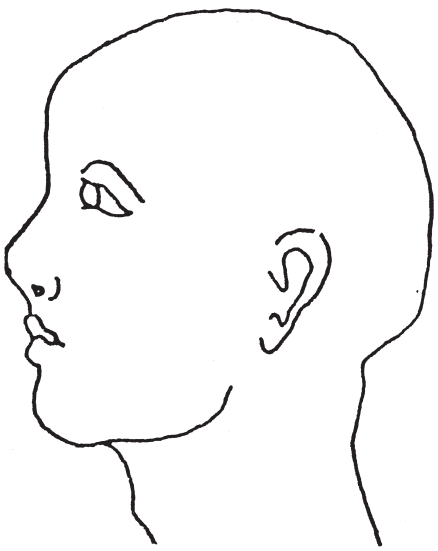


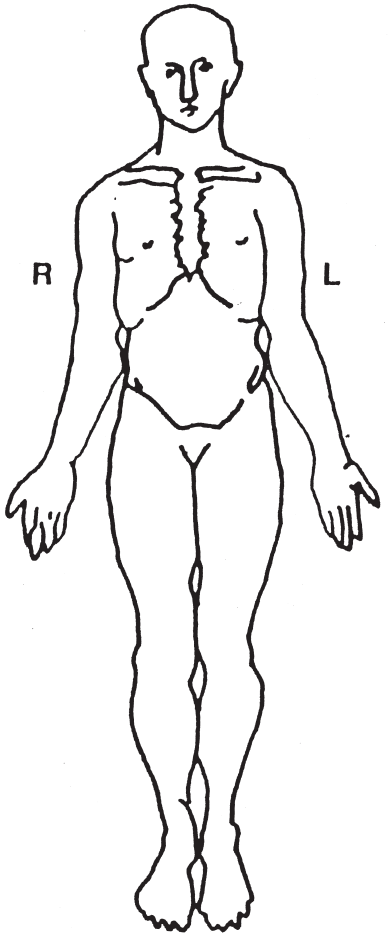
EYES

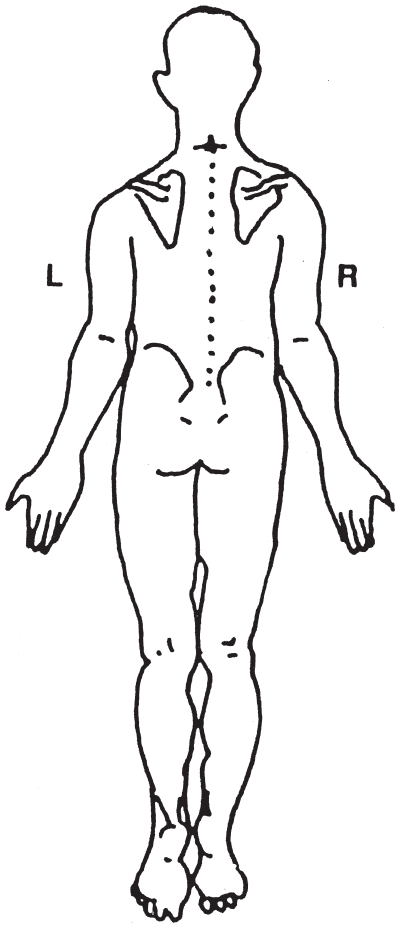
RIGHT



LEFT







Please mark the areas where you experience discomfort on the diagrams of the head, neck and body.
1. Severe = S
2. Moderate = M
3. Mild = Ml

When you have completed the diagrams, please return the questionnaire to the assistant.