TMJ Evaluation Sheet	**Patient Name:** **Date of Birth:** **Evaluation Date:** **Dentist's Name:**
Range of motion (normal = 48-52 interincisal)	
Popping/clicking of the TM joints? Unilateral or bilateral? Able to capture with anterior positioning?	
Chief Complaint (pain in the TMJ, muscle pain, headache, clicking, catching, locking, etc.) What is bothering the patient <u>the most</u>?	
Onset: when did the chief complaint start? Did something happen? How long has it bothered them?	
Palliate or Provoke: what makes the pain/problem better? What makes the pain/problem worse?	
Quality: what is the quality of the pain? Sharp, stabbing, throbbing, electrical, dull, etc.	
Region: pointing with one finger, where is the pain/ problem the worst?	
Scale: if 0 is no pain and 10 is being burned alive, what is your average pain level? What is the pain at its worst? What is the pain at its best?	
Timing: is the pain problem worse in the morning? Evening? While sleeping? When eating? Random?	
Tentative Diagnosis:	
Other notes/Plan:	