

# Diagnostic Criteria for Temporomandibular Disorders: Assessment Instruments



International Network for Orofacial Pain and Related Disorders Methodology  
A Consortium Focused On Clinical Translation Research

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# Overview

This document contains the complete assessment tools for the DC/TMD. The full download package is comprised of three documents pertaining to the use of the DC/TMD:

- Ohrbach R (editor) (2016). Diagnostic Criteria for Temporomandibular Disorders: Assessment Instruments. (this document)
- Ohrbach R, Knibbe W (2016). Diagnostic Criteria for Temporomandibular Disorders (DC/TMD): Scoring Manual for Self-Report Instruments.
- Ohrbach R, Gonzalez YM, List T, Michelotti A, Schiffman E (2014). Diagnostic Criteria for Temporomandibular Disorders (DC/TMD): Clinical Examination Protocol.

All of these documents are available at [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org). The standard source version of these documents is in English; translated versions of the assessment instruments are available in many languages. The remaining two documents are available primarily in the original English; indeed, we envision that the professional users of the DC/TMD will rely on the English language version documents for how to conduct the examination and how to score the self-report instruments.

The direct patient assessment tools rely critically on language use, either in written form for self-administration by the patient or in verbal form for use by the examiner in speaking to the patient. The tools in this document are primarily those that interface directly with the patient, yet their terminology is tied directly to the patient assessment procedures; these tools include the examination form, decision trees, and diagnostic criteria. The latter tools are also included in this document; for the translated versions of the DC/TMD, these latter tools are in either English or also in translated form.

Translations of the DC/TMD instruments were conducted according to INfORM standards; see Ohrbach R, Bjorner J, Jezewski MA, John MT, and Lobbezoo F (2013) Guidelines for Establishing Cultural Equivalency of Instruments; and Ohrbach R (2017) Translation and Adaptation of the DC/TMD Protocol, available at the same URL indicated above. Please refer to these documents for specific procedures and requirements that the translated instruments adhere to with regard to appropriate semantic and cultural validity compared to the source documents. Note that the Consortium views the assessment protocol and its instruments to be under continued development, and it also considers translated versions of those assessment instruments to be works in progress, with validation an ongoing process just as for the source instruments. Finally, the format of this document is also subject to revision; this is version 2017\_09\_29.

Disclaimer: The provision of these documents does not constitute endorsement for any empirical validity; that must be established separately and any such documentation will be made available on the Consortium website. For translated versions, full documentation of the translation process is available at the above URL as Translation Logs.

Any questions regarding this document should be directed towards the editor or, for translated versions, the translator, depending on whether the question concerns the source version in English or a translated version.

## Printing Guidance

Users of this document may want to print selected pages containing forms of interest. The below table lists the pages associated with each of the identified forms or sections of forms. Intended usage is for the user to copy the page numbers for the sections of interest and paste that information into the 'select pages' field on the printer dialog box.

Section	Page(s)
Axis I: TMD Pain Screener	9
Axis I: All clinical forms	11, 12, 14
Axis I: Clinical Examination Form (North American)	16, 17
Axis I: Clinical Examination Form (North American)	19, 20
Axis I: Pain-related Interview and Examiner Commands	See separate document
Axis I: Diagnostic trees and criteria tables	23-25, 27-29
Axis II: Screening	34, 36, 38, 42, 50
Axis II: Comprehensive	34, 36, 40, 44, 46, 48, 50

## How to Cite This Document

The below examples illustrate how to cite both this document, the translated version of the DC/TMD, as well as the associated documents which may often be cited in conjunction with this one, depending on usage. In the below citation examples, “Accessed on *<date>*” will be completed at the time a citation is used in a document (such as a manuscript).

Cite this document as follows:

Ohrbach R, editor. Diagnostic Criteria for Temporomandibular Disorders: Assessment Instruments. Version 15May2016. [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org)  
Accessed on *<date>*.

For example:

Ohrbach R, editor. Diagnostic Criteria for Temporomandibular Disorders: Assessment Instruments. Version 15May2016. [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org)  
Accessed on July 1, 2016.

There are five scenarios of usage for the three documents comprising the full assessment set, each of which will have different citation requirements.

1. Use of full DC/TMD (Axis I and Axis II)
  - a. Cite both of the following:
    - i. Ohrbach R, Gonzalez Y, List T, Michelotti A, Schiffman E. Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) Clinical Examination Protocol: Version 02June2013. [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org) Accessed on *<date>*.
    - ii. Ohrbach R, editor. Diagnostic Criteria for Temporomandibular Disorders: Assessment Instruments. Version 15May2016. [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org) Accessed on *<date>*.
2. Use of only DC/TMD Axis I. Cite the following:
  - a. Ohrbach R, Gonzalez Y, List T, Michelotti A, Schiffman E. Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) Clinical Examination Protocol: Version 02June2013. [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org) Accessed on *<date>*.
3. Use of only DC/TMD Axis II. Cite the following:
  - a. Ohrbach R, editor. Diagnostic Criteria for Temporomandibular Disorders: Assessment Instruments. Version 15May2016. [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org) Accessed on *<date>*.
4. Citation of the self-report scoring manual. Cite the following:
  - a. Ohrbach R, Knibbe W. Diagnostic Criteria for Temporomandibular Disorders: Scoring Manual for Self-Report Instruments. Version 29May2016. [www.rdc-tmdinternational.org](http://www.rdc-tmdinternational.org) Accessed on *<date>*.
5. Use of only part of the DC/TMD Axis II
  - a. If only English versions of the instruments are used, the user should cite the original source of the instrument(s) that is/are used. For example, only the TMD Pain Screener and the JFLS are used in a given application; then the user would cite Gonzalez et al, 2011, and Ohrbach et al, 2008, respectively.
  - b. If translated versions of the instruments were used, then the user would cite the source instruments as well as the fully translated assessment instrument document.

## **Acknowledgments**

The DC/TMD is the result of many, many individuals and sponsors, and the assessment instruments in this document are an outcome of that very large process. Ohrbach and Dworkin, *Journal of Dental Research*, 2016 provide, as published acknowledgments, a full list of all of the contributors to the DC/TMD from research, publications, and workshops. This document, as a container for the assessment instruments in both English and translated forms, is yet another collaboration. To that end, the editor thanks Thomas List (Malmö, Sweden) and Ambra Michelotti (Naples, Italy) for their assistance regarding the structure and formatting of the completed DC/TMD. In addition, the editor expresses gratitude to Wendy Knibbe (ACTA, Amsterdam, The Netherlands) and to Birgitta Häggman-Henrikson (University of Malmö, Sweden) for their assistance in shaping this document, the major public face of the DC/TMD assessment tools. I also thank Wendy Knibbe and Yoly Gonzalez (University at Buffalo, NY, US) for their complementary assistance in helping refine the English version of all of the assessment instruments during the first translations of the DC/TMD (to Dutch, and to Spanish, respectively) by catching mistakes and typographical errors throughout the documents. Wendy and Yoly have provided all of us with better assessment instruments.

## Axis I Assessment

Standard Usage		Instrument	Source
Screening	Complete		
✓		TMD Pain Screener	Gonzalez YM, Schiffman E, Gordon G, Seago B, Truelove EL, Slade G, Ohrbach R. Development of a brief and effective temporomandibular disorder pain screening questionnaire: reliability and validity. <i>JADA</i> 142:1183-1191, 2011.  Form version: October 11, 2013
	✓	DC/TMD Symptom Questionnaire	Impact Study Research Group Form Version: May 12, 2013
	✓	DC/TMD Demographics	Impact Study Research Group Form Version: May 12, 2013
	✓	Pain-related Interview and Examiner Commands	Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) Clinical Examination Protocol Ohrbach R, Gonzalez Y, List T, Michelotti A, Schiffman E  Form Version: May 12, 2013 Diagnosis list added November 30, 2014
	✓	Clinical Examination Form North American and FDI	Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) Clinical Examination Protocol Ohrbach R, Gonzalez Y, List T, Michelotti A, Schiffman E  Form Version: May 12, 2013 Diagnosis list added November 30, 2014

## **TMD Pain Screener**



## TMD-PAIN SCREENER

1. In the last 30 days, how long did any pain last in your jaw or temple area on either side?
  - a. No pain
  - b. Pain comes and goes
  - c. Pain is always present
  
2. In the last 30 days, have you had pain or stiffness in your jaw on awakening?
  - a. No
  - b. Yes
  
3. In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw or temple area on either side?
  - A. Chewing hard or tough food
    - a. No
    - b. Yes
  
  - B. Opening your mouth or moving your jaw forward or to the side
    - a. No
    - b. Yes
  
  - C. Jaw habits such as holding teeth together, clenching, grinding, or chewing gum
    - a. No
    - b. Yes
  
  - D. Other jaw activities such as talking, kissing, or yawning
    - a. No
    - b. Yes

## **Symptom Questionnaire**

# Diagnostic Criteria for Temporomandibular Disorders Symptom Questionnaire

Patient name \_\_\_\_\_ Date \_\_\_\_\_

## PAIN

1. Have you ever had pain in your jaw, temple, in the ear, or in front of the ear on either side? No  Yes

**If you answered NO, then skip to Question 5.**

2. How many years or months ago did your pain in the jaw, temple, in the ear, or in front of the ear first begin? \_\_\_\_\_ years \_\_\_\_\_ months

3. In the last 30 days, which of the following best describes any pain in your jaw, temple, in the ear, or in front of the ear on either side?
- Select ONE response.
- No pain
- Pain comes and goes
- Pain is always present

**If you answered NO to Question 3, then skip to Question 5.**

4. In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw, temple, in the ear, or in front of the ear on either side?

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| A. Chewing hard or tough food  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Opening your mouth, or moving your jaw forward or to the side                       | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Other jaw activities such as talking, kissing, or yawning                           | <input type="checkbox"/> | <input type="checkbox"/> |

## HEADACHE

5. In the last 30 days, have you had any headaches that included the temple areas of your head? No  Yes

**If you answered NO to Question 5, then skip to Question 8.**

6. How many years or months ago did your temple headache first begin? \_\_\_\_\_ years \_\_\_\_\_ months

7. In the last 30 days, did the following activities change any headache (that is, make it better or make it worse) in your temple area on either side?

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| A. Chewing hard or tough food  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Opening your mouth, or moving your jaw forward or to the side                 | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Jaw habits such as holding teeth together, clenching/grinding, or chewing gum | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Other jaw activities such as talking, kissing, or yawning                     | <input type="checkbox"/> | <input type="checkbox"/> |

## JAW JOINT NOISES

Office use

- |  | No                       | Yes                      | R                        | L                        | DNK                      |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 8. In the last 30 days, have you had any jaw joint noise(s) when you moved or used your jaw? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## CLOSED LOCKING OF THE JAW

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. Have you <u>ever</u> had your jaw lock or catch, even for a moment, so that it would <u>not open</u> ALL THE WAY? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

**If you answered NO to Question 9 then skip to Question 13.**

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 10. Was your jaw lock or catch severe enough to limit your jaw opening and interfere with your ability to eat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 11. In the last 30 days, did your jaw lock so you could <u>not open</u> ALL THE WAY, even for a moment, and then unlock so you could open ALL THE WAY? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

**If you answered NO to Question 11 then skip to Question 13.**

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 12. Is your jaw currently locked or limited so that your jaw will <u>not open</u> ALL THE WAY? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

## OPEN LOCKING OF THE JAW

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 13. In the last 30 days, when you opened your mouth wide, did your jaw lock or catch even for a moment such that you could <u>not close</u> it from this wide open position? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

**If you answered NO to Question 13 then you are finished.**

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 14. In the last 30 days, when you jaw locked or caught wide open, did you have to do something to get it to close including resting, moving, pushing, or maneuvering it? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

## **Demographics**

## Diagnostic Criteria for Temporomandibular Disorders

### Demographics

---

1. What is your current marital status?

Married

Living as married

Divorced

Separated

Widowed

Never married

---

2. What is your ethnicity?

Hispanic or Latino

Not Hispanic or Latino

Unknown

---

3. What is your race? Mark all that apply.

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific

White

---

4. What is the highest grade or level of schooling that you have completed?

Through high school

Some college

College graduate

Professional or Post-graduate level

---

5. What is your family's current annual household income? Please include all sources of income for all family members such as wages, salaries, investments, etc.

\$0 - \$19,999

\$20,000 - \$39,999

\$40,000 - \$59,999

\$60,000 - \$79,999

\$80,000 - \$99,999

\$100,000 - \$149,999

\$150,000 or higher

---

# **Clinical Examination Form**

**(FDI; English)**

# DC/TMD Examination Form

Date filled out (mm-dd-yyyy)

	-		-		
--	---	--	---	--	--

Patient \_\_\_\_\_ Examiner \_\_\_\_\_

## 1a. Location of Pain: Last 30 days (Select all that apply)

### RIGHT PAIN

- None  
  Temporalis  
  Other m muscles  
  Non-mast structures  
 Masseter  
  TMJ

### LEFT PAIN

- None  
  Temporalis  
  Other m muscles  
  Non-mast structures  
 Masseter  
  TMJ

## 1b. Location of Headache: Last 30 days (Select all that apply)

- None  
  Temporal  
  Other  
  None  
  Temporal  
  Other

## 2. Incisal Relationships      Reference tooth   FDI #11   FDI #21   Other

Horizontal Incisal Overjet    If negative 



 mm     
 Vertical Incisal Overlap    If negative 



 mm     
 Midline Deviation   
 Right    
 Left    
 N/A 



 mm

## 3. Opening Pattern (Supplemental; Select all that apply)

- Straight     
  Corrected deviation     
 Uncorrected Deviation  
 Right       Left

## 4. Opening Movements

### A. Pain Free Opening

--	--

 mm

### RIGHT SIDE

Pain      Familiar Pain      Familiar Headache

### LEFT SIDE

Pain      Familiar Pain      Familiar Headache

### B. Maximum Unassisted Opening

--	--

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### C. Maximum Assisted Opening

--	--

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### D. Terminated?   N   Y

## 5. Lateral and Protrusive Movements

### A. Right Lateral

--	--

 mm

### RIGHT SIDE

Pain      Familiar Pain      Familiar Headache

### LEFT SIDE

Pain      Familiar Pain      Familiar Headache

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### B. Left Lateral

--	--

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### C. Protrusion

--	--

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

If negative



**6. TMJ Noises During Open & Close Movements**

	RIGHT TMJ					
	Examiner		Patient	Pain w/ Click	Familiar Pain	
	Open	Close				
Click	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input checked="" type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Crepitus	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

	LEFT TMJ					
	Examiner		Patient	Pain w/ Click	Familiar Pain	
	Open	Close				
Click	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input checked="" type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Crepitus	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

**7. TMJ Noises During Lateral & Protrusive Movements**

	RIGHT TMJ					
	Examiner		Patient	Pain w/ Click	Familiar Pain	
Click	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input checked="" type="radio"/> Y
Crepitus	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

	LEFT TMJ					
	Examiner		Patient	Pain w/ Click	Familiar Pain	
Click	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input checked="" type="radio"/> Y
Crepitus	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

**8. Joint Locking**

	RIGHT TMJ					
	Locking	Reduction		Pain w/ Click	Familiar Pain	
		Patient	Examiner			
While Opening	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Wide Open Position	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

	LEFT TMJ					
	Locking	Reduction		Pain w/ Click	Familiar Pain	
		Patient	Examiner			
While Opening	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Wide Open Position	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

**9. Muscle & TMJ Pain with Palpation**

	RIGHT SIDE							
	Pain	Familiar Pain		Familiar Headache		Referred Pain		
<b>(1 kg)</b>								
Temporalis (posterior)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Temporalis (middle)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Temporalis (anterior)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Masseter (origin)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input type="radio"/> Y
Masseter (body)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input type="radio"/> Y
Masseter (insertion)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input type="radio"/> Y
<b>TMJ</b>								
Lateral pole ( <b>0.5 kg</b> )	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Around lateral pole ( <b>1 kg</b> )	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

	LEFT SIDE							
	Pain	Familiar Pain		Familiar Headache		Referred Pain		
<b>(1 kg)</b>								
Temporalis (posterior)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Temporalis (middle)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Temporalis (anterior)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Masseter (origin)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input type="radio"/> Y
Masseter (body)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input type="radio"/> Y
Masseter (insertion)	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y			<input type="radio"/> N	<input type="radio"/> Y
<b>TMJ</b>								
Lateral pole ( <b>0.5 kg</b> )	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Around lateral pole ( <b>1 kg</b> )	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

**10. Supplemental Muscle Pain with Palpation**

	RIGHT SIDE			
	Pain	Familiar Pain		Referred Pain
<b>(0.5 kg)</b>				
Posterior mandibular region	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Submandibular region	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Lateral pterygoid area	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Temporalis tendon	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

	LEFT SIDE			
	Pain	Familiar Pain		Referred Pain
<b>(0.5 kg)</b>				
Posterior mandibular region	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Submandibular region	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Lateral pterygoid area	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y
Temporalis tendon	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y

**11. Diagnoses**

Pain Disorders	Right TMJ Disorders	Left TMJ Disorders
<input type="radio"/> None	<input type="radio"/> None	<input type="radio"/> None
<input type="radio"/> Myalgia	<input type="radio"/> Disc displacement (select one)	<input type="radio"/> Disc displacement (select one)
<input type="radio"/> Myofascial pain with referral	<input type="radio"/> ...with reduction	<input type="radio"/> ...with reduction
<input type="radio"/> Right Arthralgia	<input type="radio"/> ...with reduction, with intermittent locking	<input type="radio"/> ...with reduction, with intermittent locking
<input type="radio"/> Left Arthralgia	<input type="radio"/> ... without reduction, with limited opening	<input type="radio"/> ... without reduction, with limited opening
<input type="radio"/> Headache attributed to TMD	<input type="radio"/> ... without reduction, without limited opening	<input type="radio"/> ... without reduction, without limited opening
	<input type="radio"/> Degenerative joint disease	<input type="radio"/> Degenerative joint disease
	<input type="radio"/> Subluxation	<input type="radio"/> Subluxation

**12. Comments**

**Clinical Examination Form**  
**(North American; English)**

# DC/TMD Examination Form

Date filled out (mm-dd-yyyy)

--	--	--	--	--	--	--	--	--	--	--

Patient \_\_\_\_\_ Examiner \_\_\_\_\_

## 1a. Location of Pain: Last 30 days (Select all that apply)

### RIGHT PAIN

- None  
  Temporalis  
  Other m muscles  
  Non-mast structures  
 Masseter  
  TMJ

### LEFT PAIN

- None  
  Temporalis  
  Other m muscles  
  Non-mast structures  
 Masseter  
  TMJ

## 1b. Location of Headache: Last 30 days (Select all that apply)

- None  
  Temporal  
  Other  
  None  
  Temporal  
  Other

## 2. Incisal Relationships Reference tooth US #8   US #9   Other

Horizontal Incisal Overjet  
  If negative 



 mm  
 Vertical Incisal Overlap  
  If negative 



 mm  
 Midline Deviation  
 Right   
 Left   
 N/A 



 mm

## 3. Opening Pattern (Supplemental; Select all that apply)

- Straight  
  Corrected deviation  
 Uncorrected Deviation  
 Right  
  Left

## 4. Opening Movements

### A. Pain Free Opening

 mm

### RIGHT SIDE

Pain   Familiar Pain   Familiar Headache

### LEFT SIDE

Pain   Familiar Pain   Familiar Headache

### B. Maximum Unassisted Opening

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### C. Maximum Assisted Opening

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### D. Terminated? N Y

## 5. Lateral and Protrusive Movements

### A. Right Lateral

 mm

### RIGHT SIDE

Pain   Familiar Pain   Familiar Headache

### LEFT SIDE

Pain   Familiar Pain   Familiar Headache

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### B. Left Lateral

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

### C. Protrusion

 mm

Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	Temporalis	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Masseter	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		TMJ	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Other M Musc	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	
Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		Non-mast	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	

If negative

**6. TMJ Noises During Open & Close Movements**

	RIGHT TMJ				
	Examiner		Patient	Pain w/ Click	Familiar Pain
	Open	Close			
Click	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input checked="" type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Crepitus	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		

	LEFT TMJ				
	Examiner		Patient	Pain w/ Click	Familiar Pain
	Open	Close			
Click	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input checked="" type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Crepitus	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		

**7. TMJ Noises During Lateral & Protrusive Movements**

	Examiner		Patient	Pain w/ Click	Familiar Pain
Click	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input checked="" type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Crepitus	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y			

	Examiner		Patient	Pain w/ Click	Familiar Pain
Click	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input checked="" type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Crepitus	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y			

**8. Joint Locking**

	RIGHT TMJ			
	Locking	Reduction		Familiar Pain
		Patient	Examiner	
While Opening	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Wide Open Position	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y

	LEFT TMJ			
	Locking	Reduction		Familiar Pain
		Patient	Examiner	
While Opening	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Wide Open Position	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y

**9. Muscle & TMJ Pain with Palpation**

	RIGHT SIDE			
	Pain	Familiar Pain	Familiar Headache	Referred Pain
<b>(1 kg)</b>				
Temporalis (posterior)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Temporalis (middle)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Temporalis (anterior)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter (origin)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
Masseter (body)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
Masseter (insertion)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
<b>TMJ</b>				
Lateral pole (0.5 kg)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
Around lateral pole (1 kg)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y

	LEFT SIDE			
	Pain	Familiar Pain	Familiar Headache	Referred Pain
<b>(1 kg)</b>				
Temporalis (posterior)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Temporalis (middle)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Temporalis (anterior)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Masseter (origin)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
Masseter (body)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
Masseter (insertion)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
<b>TMJ</b>				
Lateral pole (0.5 kg)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y
Around lateral pole (1 kg)	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y		<input type="radio"/> N <input type="radio"/> Y

**10. Supplemental Muscle Pain with Palpation**

	RIGHT SIDE		
	Pain	Familiar Pain	Referred Pain
<b>(0.5 kg)</b>			
Posterior mandibular region	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Submandibular region	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Lateral pterygoid area	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Temporalis tendon	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y

	LEFT SIDE		
	Pain	Familiar Pain	Referred Pain
<b>(0.5 kg)</b>			
Posterior mandibular region	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Submandibular region	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Lateral pterygoid area	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
Temporalis tendon	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y

**11. Diagnoses**

- Pain Disorders**
- None
  - Myalgia
  - Myofascial pain with referral
  - Right Arthralgia
  - Left Arthralgia
  - Headache attributed to TMD

- Right TMJ Disorders**
- None
  - Disc displacement (select one)
    - ...with reduction
    - ...with reduction, with intermittent locking
    - ... without reduction, with limited opening
    - ... without reduction, without limited opening
  - Degenerative joint disease
  - Subluxation

- Left TMJ Disorders**
- None
  - Disc displacement (select one)
    - ...with reduction
    - ...with reduction, with intermittent locking
    - ... without reduction, with limited opening
    - ... without reduction, without limited opening
  - Degenerative joint disease
  - Subluxation

**12. Comments**

# Diagnosis

Instrument	Source
<p>Diagnostic Decision Trees, as based on published criteria</p>	<p>The Decision Trees were created for the Consortium website and community, and reside in the public domain. Their scientific linkage, however, is to the following:</p> <p>Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) for Clinical and Research Applications: Recommendations of the International RDC/TMD Consortium Network* and Orofacial Pain Special Interest Group**</p> <p>Schiffman E, Ohrbach R, Truelove E, Look J, Anderson G, Goulet J-P, List T, Svensson P, Gonzalez Y, Lobbezoo F, Michelotti A, Brooks S, Ceusters W, Drangsholt M, Ettlin D, Gaul C, Goldberg LJ, Haythornthwaite J, Hollender L, Jensen R, John MT, deLaat A, deLeeuw R, Maixner W, van der Meulen M, Murray GM, Nixdorf DR, Palla S, Petersson A, Pionchon P, Smith B, Visscher C, Zakrzewska J, and Dworkin SF (2014). <i>Journal of Oral &amp; Facial Pain and Headache</i> 28:6-27.</p> <p>Figure Version: January 24, 2014</p>
<p>Diagnostic Criteria Table, as based on published criteria</p>	<p>The Diagnostic Criteria Table was created for the Consortium website and community, and reside in the public domain. Their scientific linkage, however, is to the following:</p> <p>Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) for Clinical and Research Applications: Recommendations of the International RDC/TMD Consortium Network* and Orofacial Pain Special Interest Group**</p> <p>Schiffman E, Ohrbach R, Truelove E, Look J, Anderson G, Goulet J-P, List T, Svensson P, Gonzalez Y, Lobbezoo F, Michelotti A, Brooks S, Ceusters W, Drangsholt M, Ettlin D, Gaul C, Goldberg LJ, Haythornthwaite J, Hollender L, Jensen R, John MT, deLaat A, deLeeuw R, Maixner W, van der Meulen M, Murray GM, Nixdorf DR, Palla S, Petersson A, Pionchon P, Smith B, Visscher C, Zakrzewska J, and Dworkin SF (2014). <i>Journal of Oral &amp; Facial Pain and Headache</i> 28:6-27.</p> <p>Table Version: October 23, 2015</p>

## Decision Tree

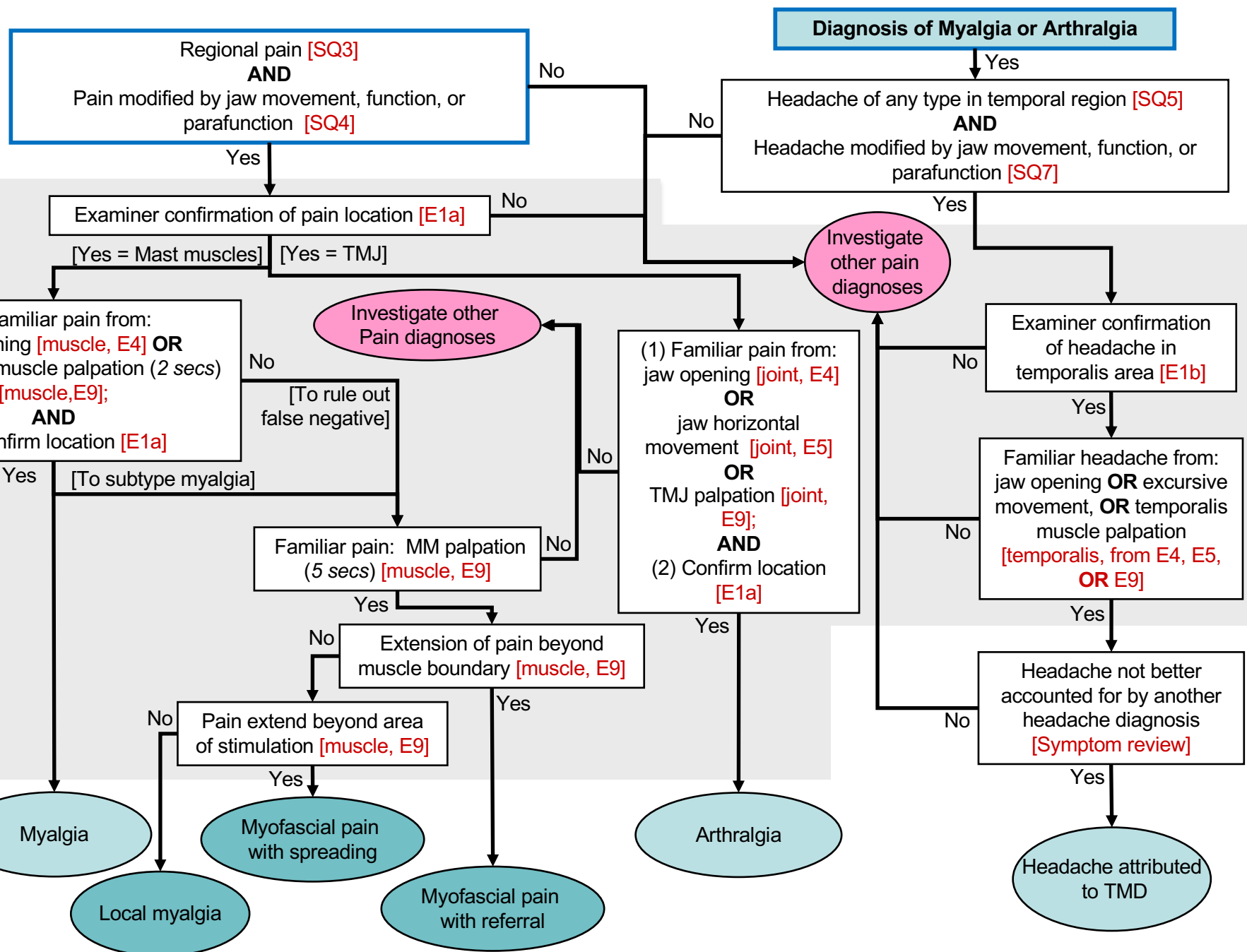
# Diagnostic Criteria for Temporomandibular Disorders (DC/TMD): Diagnostic Decision Tree

## Pain-Related TMD and Headache

**HISTORY**  
Start at each  
blue-outline box

**EXAMINATION**

**DIAGNOSIS**



Note: 2 secs palpation is sufficient for myalgia; 5-secs is required for subtypes

Version 7/4/2018 (text revision)

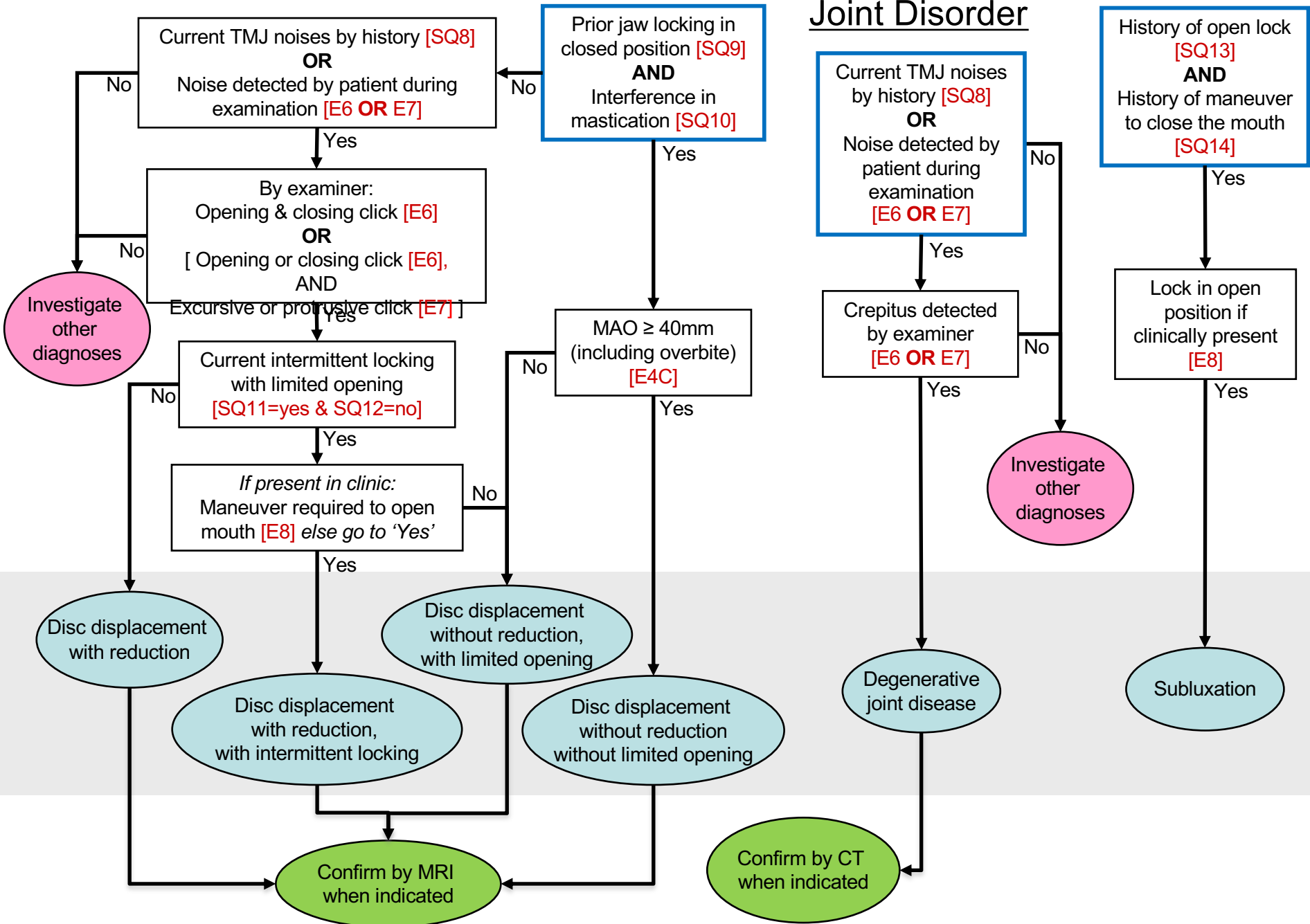
# Diagnostic Criteria for Temporomandibular Disorders (DC/TMD): Diagnostic Decision Tree

**HISTORY & EXAMINATION**  
 Start at each blue-outline box  
**CLINICAL DIAGNOSIS**  
**IMAGING**

## Intra-articular Joint Disorders

## Degenerative Joint Disorder

## Subluxation





## Updates to the decision tree

2018\_07\_04. Slide 1: change “Myofascial pain” to “Myofascial pain with spreading”.

2016\_09\_05. Slide 2: add “By examiner” to the joint noise box in the path for disc displacement with reduction diagnosis, in order to distinguish noise identified by the examiner, vs noise identified by the patient, as indicated clearly in the box at the top of the slide. This change is also consistent with what was already in place for the DJD diagnostic path.

## **Diagnostic Criteria Table**

## Diagnostic Criteria for the Most Common Temporomandibular Disorders: Symptom Questionnaire and Clinical Examination Items

All listed criteria in History (DC/TMD Symptom Questionnaire) and Examination (DC/TMD Examination Form) are required for the specific Diagnosis unless otherwise stated; each criterion is positive unless otherwise specified. Exact time period for time-relevant History or Examination items is not specified below since that is a function of how the items are constructed to suit a given purpose; the logic does not change according to time period. The time period as assessed by history items for disc displacement without reduction vs with reduction is relative.

Source: Schiffman E, Ohrbach R, Truelove E, Look J, Anderson G, Goulet J-P, List T, Svensson P, Gonzalez Y, Lobbezoo F, Michelotti A, Brooks S, Ceusters W, Drangsholt M, Ettl D, Gaul C, Goldberg LJ, Haythornthwaite J, Hollender L, Jensen R, John MT, deLaat A, deLeeuw R, Maixner W, van der Meulen M, Murray GM, Nixdorf DR, Palla S, Petersson A, Pionchon P, Smith B, Visscher C, Zakrzewska J, and Dworkin SF (2014). Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) for Clinical and Research Applications: Recommendations of the International RDC/TMD Consortium Network and Orofacial Pain Special Interest Group. *Journal of Oral & Facial Pain and Headache* 28:6-27.

Version 2/6/2020

Disorder	History		Examination	
	Criteria	SQ	Criteria	Examination Form
<b>Pain Disorders</b>				
Myalgia (ICD-9 729.1) • Sens 0.90 • Spec 0.95	Pain in a masticatory structure	SQ3	Confirmation of pain in masticatory muscle(s)	E1a
	Pain modified by jaw movement, function, or parafunction	SQ4	Familiar pain in masticatory muscle(s) with either muscle palpation or maximum opening	E4b, E4c, or E9: familiar pain in temporalis or masseter, or in other masticatory muscles if also relevant; <b>or</b> E10: familiar pain in supplemental muscles, if E10 included
<b>Myalgia Subtypes</b>				
<u>Local Myalgia</u> (ICD-9 729.1)  Sens and Spec not established	[same as for Myalgia]	[SQ3 & SQ4]	Confirmation of pain in masticatory muscle(s)	E1a
			Familiar pain with muscle palpation	E9: familiar pain in masseter or temporalis; <b>or</b> E10: familiar pain in supplemental muscles, if E10 included
			Pain remains local to the area of stimulation	E9: negative referred and spreading pain; <b>and</b> E10: negative referred and spreading pain, if E10 included
<u>Myofascial Pain with Spreading</u> (ICD-9 729.1)  Sens and Spec not established	[same as for Myalgia]	[SQ3 & SQ4]	Confirmation of pain in masticatory muscle(s)	E1a
			Familiar pain with muscle palpation	E9: familiar pain in masseter or temporalis; <b>or</b> E10: familiar pain in supplemental muscles, if E10 included
			Spreading (but not referred) pain with muscle palpation	E9: spreading pain; <b>or</b> E10: spreading pain, if E10 included; <b>AND</b> E9: negative referred pain; <b>and</b> E10: negative referred pain, if E10 included

	History		Examination	
<i>Disorder</i>	<i>Criteria</i>	<i>SQ</i>	<i>Criteria</i>	<i>Examination Form</i>
<u>Myofascial Pain with Referral</u> (ICD-9 729.1) <ul style="list-style-type: none"> <li>• Sens 0.86</li> <li>• Spec 0.98</li> </ul>	[same as for Myalgia]	[SQ3 & SQ4]	Confirmation of pain in masticatory muscle(s)	E1a
			Familiar pain with muscle palpation	E9: familiar pain in masseter or temporalis; <b>or</b> E10: familiar pain in supplemental muscles, if E10 included
			Referred pain with muscle palpation	E9: positive referred pain; <b>or</b> E10: positive referred pain, if E10 included
Arthralgia (ICD-9 524.62) <ul style="list-style-type: none"> <li>• Sens 0.89</li> <li>• Spec 0.98</li> </ul>	Pain in a masticatory structure	SQ3	Confirmation of pain in TMJ(s)	E1a
	Pain modified by jaw movement, function, or parafunction	SQ4	Familiar pain with TMJ palpation or range of motion	E4b, E4c, E5a-c, or E9: familiar pain in TMJ
Headache Attributed to TMD (ICD-9 339.89 [other specified headache syndrome], or ICD-9 784.0 [headache]) <ul style="list-style-type: none"> <li>• Sens 0.89</li> <li>• Spec 0.87</li> </ul> Note that for a secondary headache diagnosis, a primary diagnosis of either myalgia or arthralgia is required.	Headache of any type in temporal region	SQ5	Confirmation of headache in temporalis muscle	E1b
	Headache affected by jaw movement, function, or parafunction	SQ7	Report of familiar headache in temporalis area from either: a. Palpation of the temporalis muscle <b>or</b> b. Range of motion of jaw	E4b, E4c, E5a-c, or E9: familiar headache pain in the temporalis muscle

	History		Examination	
<i>Disorder</i>	<i>Criteria</i>	<i>SQ</i>	<i>Criteria</i>	<i>Examination Form</i>
<b>Joint Disorders</b>				
Disc Displacement with Reduction (ICD-9 524.63) • Sens 0.34 • Spec 0.92	Current TMJ noises by history, <b>OR</b>	SQ8	Click(s) with opening <u>and</u> closing, <b>OR</b>	E6: (open & close) click, <b>OR</b>
	Patient reports noise during the examination	E6 or E7: noise reported by patient	Both (a) click with opening or closing, <b>and</b> (b) click with lateral or protrusive movements	E6: (open or close) click, <b>and</b> E7: (protrusive or lateral) click
Disc Displacement with Reduction, with Intermittent Locking (ICD-9 524.63) • Sens 0.38 • Spec 0.98	[same as disc displacement with reduction]	[same as DD with red]	[same as disc displacement with reduction]	[same as DD with red]
	Current intermittent locking with limited opening	SQ11=yes SQ12=no	When disorder present in clinic: maneuver required to open mouth	E8 (optional)
Disc Displacement without Reduction, with Limited Opening (ICD-9 524.63) • Sens 0.80 • Spec 0.97	Current* TMJ lock with limited opening	SQ9	Passive stretch (maximum assisted opening) < 40mm	E4c < 40mm including vertical incisal overlap
	Limitation severe enough to interfere with ability to eat	SQ10		
Disc Displacement without Reduction, without Limited Opening (ICD-9 524.63) • Sens 0.54 • Spec 0.79	Prior* TMJ lock with limited opening	SQ9	Passive stretch (maximum assisted opening) ≥ 40mm	E4c ≥ 40mm including vertical incisal overlap
	Limitation severe enough to interfere with ability to eat	SQ10		
Degenerative Joint Disease (ICD-9 715.18) • Sens 0.55 • Spec 0.61	Current TMJ noises by history, <b>OR</b>	SQ8	Crepitus during jaw movement	E6 or E7: crepitus detected by examiner
	Patient reports noise during the examination	E6 or E7: noise reported by patient		
Subluxation (ICD-9 830.0) • Sens 0.98 • Spec 1.00	TMJ locking or catching in wide open jaw position	SQ13	When disorder present in clinic: maneuver required to close mouth	E8 (optional)
	Unable to close mouth without specific maneuver	SQ14		

\* “Current” and “Prior” (as based on S9) for distinguishing, respectively, the “with limitation” vs “without limitation” variants of Disc Displacement without Reduction are interpreted based on change over time as determined by history and as confirmed by the clinical examination for jaw range of motion.

## Changes to this document

### Feb 6, 2020

- “Myofascial Pain” revised to “Myofascial Pain with Spreading”, to reconcile the table with the decision tree previously updated.

### July 4, 2018

- For Disk Displacement with Reduction, Examination E7 was clarified by adding “(protrusive or lateral)” for the type of click expected to fulfill criterion.

### Oct 23, 2015

- Incorrect sensitivity and specificity values were present for some disorders; this error was identified by an observant translation team leader, and the error is assumed to have emerged during preparation of the table prior to computation of final sensitivity and specificity estimates for the published DC/TMD.

### May 25, 2014

- Added “**OR**” to “Current TMJ noises by history” for each of Disc Displacement with Reduction and Degenerative Joint Disease, as per published DC/TMD.
- Added diagnostic criterion note to Headache Secondary to TMD, with regard to necessity of either a myalgia or arthralgia diagnosis in order to have a secondary headache.
- Corrected minor punctuation discrepancies.

### April 29, 2014

- Corrected name of disorder “myofascial pain”; was incorrectly stated as “myofascial pain with spreading”.

## Axis II Assessment

Standard Usage		Instrument	Source
Screening	Complete		
✓	✓	Pain Drawing	Impact Study Research Group Form Version: May 12, 2013
✓	✓	Graded Chronic Pain Scale Version 2.0	Von Korff M. Assessment of chronic pain in epidemiological and health services research: empirical bases and new directions. In: Turk DC, Melzack R, editors. <i>Handbook of Pain Assessment</i> , Third Edition. New York: Guilford Press. 2011. pp 455 – 473.  Form Version: May 12, 2013
✓		Jaw Functional Limitations Scale - 8-item	Ohrbach R, Larsson P, and List T. The Jaw Functional Limitation Scale: Development, reliability, and validity of 8-item and 20-item versions. <i>J.Orfacial Pain</i> 22:219-230, 2008.  Form Version: May 12, 2013
	✓	Jaw Functional Limitations Scale - 20-item	Ohrbach R, Larsson P, and List T. The Jaw Functional Limitation Scale: Development, reliability, and validity of 8-item and 20-item versions. <i>J.Orfacial Pain</i> 22:219-230, 2008.  Form Version: May 12, 2013
✓		PHQ-4	Kroenke K, Spitzer RL, Williams JB, and Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. <i>Psychosomatics</i> 50 (6):613-621, 2009.  A text-revision of this instrument is posted at <a href="http://www.phqscreeners.com/">http://www.phqscreeners.com/</a> and incorporated into the final instrument for the Consortium.  Form Version: May 12, 2013

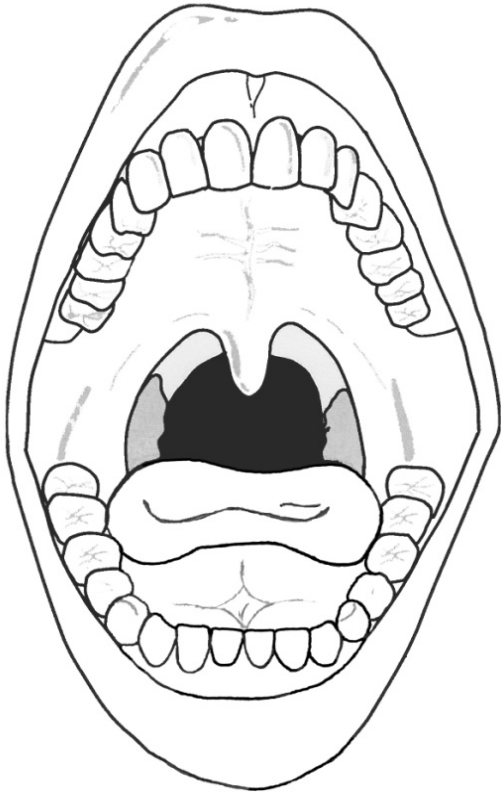
Standard Usage		Instrument	Source
Screening	Complete		
	✓	PHQ-9	<p>Kroenke K, Spitzer RL, and Williams JB. The PHQ-9: validity of a brief depression severity measure. <i>Journal of General Internal Medicine</i> 16 (9):606-613, 2001.</p> <p>A text-revision of this instrument is posted at <a href="http://www.phqscreeners.com/">http://www.phqscreeners.com/</a> and incorporated into the final instrument for the Consortium.</p> <p>Form Version: May 12, 2013</p>
	✓	GAD-7	<p>Spitzer RL, Kroenke K, Williams JB, and Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. <i>Arch.Intern.Med.</i> 166 (10):1092-1097, 2006.</p> <p>A text-revision of this instrument is posted at <a href="http://www.phqscreeners.com/">http://www.phqscreeners.com/</a> and incorporated into the final instrument for the Consortium.</p> <p>Form Version: May 12, 2013</p>
	✓	PHQ-15	<p>Kroenke K, Spitzer RL, and Williams JB. The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. <i>Psychosom.Med.</i> 64 (2):258-266, 2002.</p> <p>Form Version: May 12, 2013</p>
✓	✓	Oral Behaviors Checklist	<p>Ohrbach R, Markiewicz MR, and McCall WD Jr. Waking-state oral parafunctional behaviors: specificity and validity as assessed by electromyography. <i>European Journal of Oral Sciences</i> 116:438-444, 2008.</p> <p>Ohrbach R et al. Oral Behaviors Checklist: Development and validation. Forthcoming.</p> <p>Form Version: May 12, 2013</p>



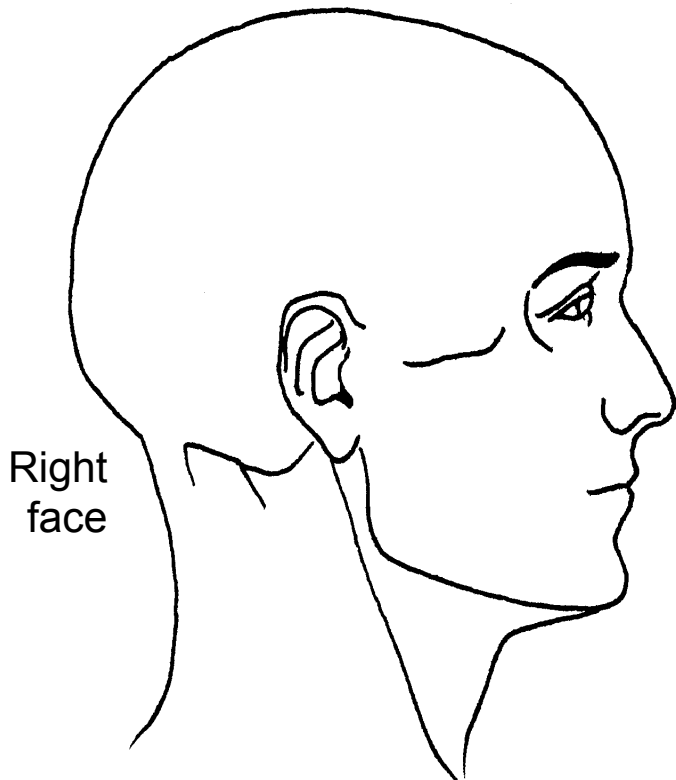
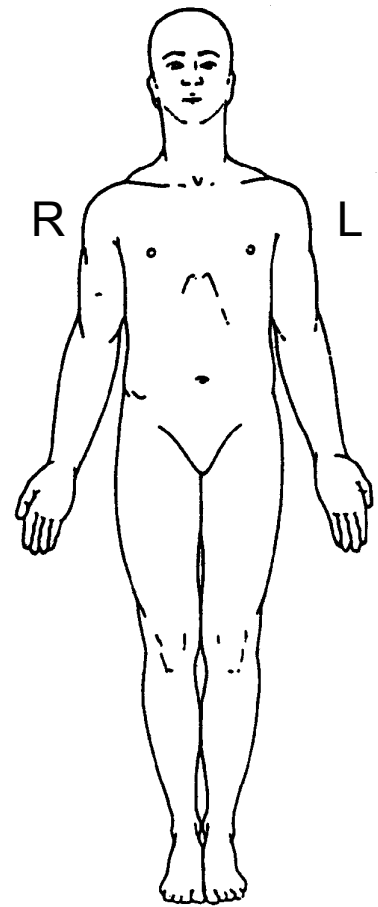
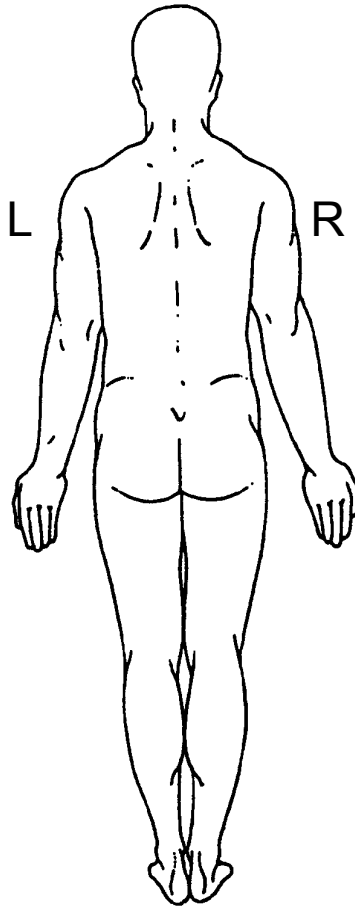
## **Pain Drawing**

# PAIN DRAWING

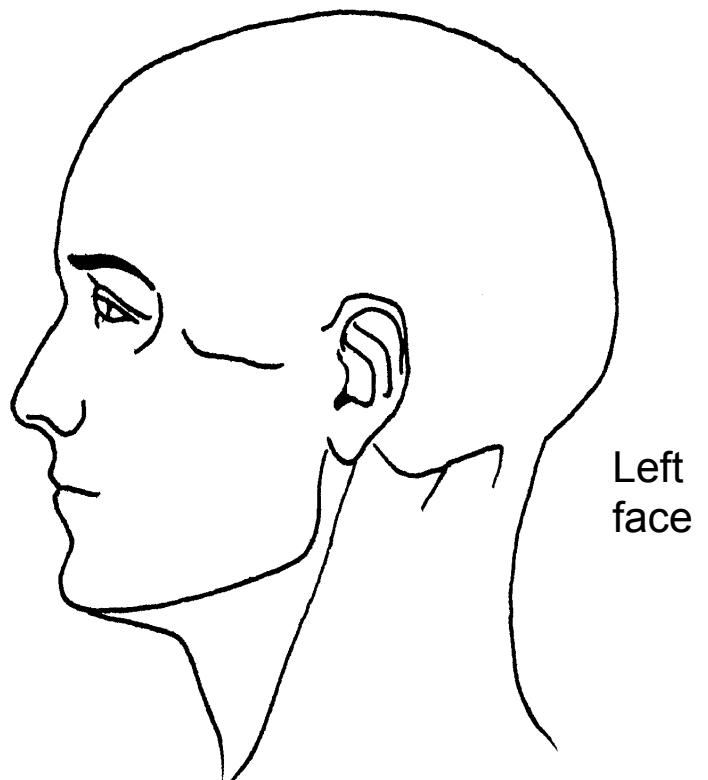
Indicate the location of ALL of your different pains by shading in the area, using the diagrams that are most relevant. If there is an exact spot where the pain is located, indicate with a solid dot (●). If your pain moves from one location to another, use arrows to show the path.



Mouth and teeth



Right face



Left face

## **Graded Chronic Pain (version 2)**

## Graded Chronic Pain Scale Version 2.0

1. On how many days in the **last 6 months** have you had facial pain? \_\_\_\_\_ Days

2. How would you rate your facial pain **RIGHT NOW?** Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain											Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10	

3. In the LAST 30 DAYS, how would you rate your **WORST** facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain											Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10	

4. In the LAST 30 DAYS, **ON AVERAGE**, how would you rate your facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be". [That is, *your usual pain* at times you were in pain.]

No pain											Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10	

5. In the LAST 30 DAYS, how many days did your facial pain keep you from doing your **USUAL ACTIVITIES** like work, school, or housework? (every day = 30 days) \_\_\_\_\_ Days

6. In the LAST 30 DAYS, how much has facial pain interfered with your **DAILY ACTIVITIES**? Use a 0-10 scale, where 0 is "no interference: and 10 is "unable to carry on any activities".

No interference											Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10	

7. In the LAST 30 DAYS, how much has facial pain interfered with your **RECREATIONAL, SOCIAL AND FAMILY ACTIVITIES**? Use the same scale, where 0 is "no interference: and 10 is "unable to carry on any activities".

No interference											Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10	

8. In the LAST 30 DAYS, how much has facial pain interfered with your **ABILITY TO WORK**, including housework? Use the same scale, where 0 is "no interference: and 10 is "unable to carry on any activities".

No interference											Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10	

**JFLS-8**

## Jaw Functional Limitation Scale – 8

For each of the items below, please indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, leave the item blank.

		No limitation										Severe Limitation		
1.	Chew tough food	0	1	2	3	4	5	6	7	8	9	10		
2.	Chew chicken (e.g., prepared in oven)	0	1	2	3	4	5	6	7	8	9	10		
3.	Eat soft food requiring no chewing (e.g., mashed potatoes, apple sauce, pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10		
4.	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10		
5.	Swallow	0	1	2	3	4	5	6	7	8	9	10		
6.	Yawn	0	1	2	3	4	5	6	7	8	9	10		
7.	Talk	0	1	2	3	4	5	6	7	8	9	10		
8.	Smile	0	1	2	3	4	5	6	7	8	9	10		

**JFLS-20**

## Jaw Functional Limitation Scale – 20

For each of the items below, please indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, leave the item blank.

		No limitation										Severe limitation		
		0	1	2	3	4	5	6	7	8	9	10		
1.	Chew tough food	0	1	2	3	4	5	6	7	8	9	10		
2.	Chew hard bread	0	1	2	3	4	5	6	7	8	9	10		
3.	Chew chicken (e.g., prepared in oven)	0	1	2	3	4	5	6	7	8	9	10		
4.	Chew crackers	0	1	2	3	4	5	6	7	8	9	10		
5.	Chew soft food (e.g., macaroni, canned or soft fruits, cooked vegetables, fish)	0	1	2	3	4	5	6	7	8	9	10		
6.	Eat soft food requiring no chewing (e.g., mashed potatoes, apple sauce, pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10		
7.	Open wide enough to bite from a whole apple	0	1	2	3	4	5	6	7	8	9	10		
8.	Open wide enough to bite into a sandwich	0	1	2	3	4	5	6	7	8	9	10		
9.	Open wide enough to talk	0	1	2	3	4	5	6	7	8	9	10		
10.	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10		
11.	Swallow	0	1	2	3	4	5	6	7	8	9	10		
12.	Yawn	0	1	2	3	4	5	6	7	8	9	10		
13.	Talk	0	1	2	3	4	5	6	7	8	9	10		
14.	Sing	0	1	2	3	4	5	6	7	8	9	10		
15.	Putting on a happy face	0	1	2	3	4	5	6	7	8	9	10		
16.	Putting on an angry face	0	1	2	3	4	5	6	7	8	9	10		
17.	Frown	0	1	2	3	4	5	6	7	8	9	10		
18.	Kiss	0	1	2	3	4	5	6	7	8	9	10		
19.	Smile	0	1	2	3	4	5	6	7	8	9	10		
20.	Laugh	0	1	2	3	4	5	6	7	8	9	10		



**PHQ-4**

## Patient Health Questionnaire - 4

Over the last 2 weeks, how often have you been bothered by the following problems?  
Please place a check mark in the box to indicate your answer.

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL SCORE =

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PHQ-9**

## Patient Health Questionnaire - 9

Over the last 2 weeks, how often have you been bothered by the following problems?  
Please place a check mark in the box to indicate your answer.

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thinking that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL SCORE =

If you checked off <u>any</u> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GAD-7**

## GAD - 7

Over the last 2 weeks, how often have you been bothered by the following problems?  
Place a check mark in the box to indicate your answer.

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL SCORE =

If you checked off <u>any</u> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PHQ-15**

## Patient Health Questionnaire-15: Physical Symptoms

During the last 4 weeks, how much have you have been bothered by any of the following problems? Please place a check mark in the box to indicate your answer.

	Not bothered 0	Bothered a little 1	Bothered a lot 2
1. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Menstrual cramps or other problems with your periods [women only]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL SCORE =



## **Oral Behaviors Checklist**

# The Oral Behavior Checklist

How often do you do each of the following activities, based on **the last month**? If the frequency of the activity varies, choose the higher option. Please place a (✓) response for each item and do not skip any items.

Activities During Sleep		None of the time	< 1 Night /Month	1-3 Nights /Month	1-3 Nights /Week	4-7 Nights/ Week
1	Clench or grind teeth <b>when asleep</b> , based on any information you may have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activities During Waking Hours		None of the time	A little of the time	Some of the time	Most of the time	All of the time
3	Grind teeth together <b>during waking hours</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Clench teeth together <b>during waking hours</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Hold, tighten, or tense muscles without clenching or bringing teeth together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Hold or jut jaw forward or to the side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Press tongue forcibly against teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Place tongue between teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Bite, chew, or play with your tongue, cheeks or lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Hold jaw in rigid or tense position, such as to brace or protect the jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Use chewing gum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Play musical instrument that involves use of mouth or jaw (for example, woodwind, brass, string instruments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Lean with your hand on the jaw, such as cupping or resting the chin in the hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Chew food on one side only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Eating between meals (that is, food that requires chewing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Sustained talking (for example, teaching, sales, customer service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Singing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Yawning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Hold telephone between your head and shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>