

CRANIOMANDIBULAR SYMPTOM SHEET

PATIENT _____

DATE _____

MSO _____ mm

LF _____ mm

RT _____ mm

PRO _____ mm

Do you experience the following?

EYES:

- | | |
|--------------------------|--------------|
| 1. Pain around eyes? | 1. N R S U A |
| 2. Blurred vision? | 2. N R S U A |
| 3. Pressure behind eyes? | 3. N R S U A |
| 4. Pain behind eyes? | 4. N R S U A |
| 5. Light sensitivity? | 5. N R S U A |
| 6. Watering eyes? | 6. N R S U A |

HEAD AND/OR FACE:

- | | |
|---------------------------|--------------|
| 1. Forehead pain? | 1. N R S U A |
| 2. Temple pain? | 2. N R S U A |
| 3. Facial muscle cramps? | 3. N R S U A |
| 4. Facial pain? | 4. N R S U A |
| 5. Headaches? | 5. N R S U A |
| 6. Pain in back of head? | 6. N R S U A |
| 7. Pain in scalp or hair? | 7. N R S U A |

MOUTH:

- | | |
|--|---------------|
| 1. Have limited opening? | 1. N R S U A |
| 2. Chewing difficulties? | 2. N R S U A |
| 3. Chewing hurts? | 3. N R S U A |
| 4. Jaw deviates to one side when opening wide? | 4. N R S U A |
| 5. Hurts to speak? | 5. N R S U A |
| 6. Can't find the bite? | 6. N R S U A |
| 7. Bite feels different? | 7. N R S U A |
| 8. Teeth sensitive or ache? | 8. N R S U A |
| 9. Clench or grind teeth? | 9. N R S U A |
| 10. Teeth Loose? | 10. N R S U A |
| 11. Teeth that ache? | 11. N R S U A |

JAW JOINT PAIN:

- | | |
|--|--------------|
| 1. Pain right side? | 1. N R S U A |
| 2. Pain left side? | 2. N R S U A |
| 3. Jaw sticks open/closed? | 3. N R S U A |
| 4. Unintentional biting of cheek, lip or tongue? | 4. N R S U A |
| 5. TMJ clicking/popping? | 5. N R S U A |
| 6. TMJ grating/cracking? | 6. N R S U A |
| 7. Uncontrolled jaw or tongue movements? | 7. N R S U A |

**N=Never; R=Rarely; S=Sometimes;
U=Usually; A=Always**

EARS & BALANCE:

- | | |
|---|--------------|
| 1. Ears hissing/buzzing/ringing/roaring | 1. N R S U A |
| 2. Diminished hearing? | 2. N R S U A |
| 3. Ear pain without infection? | 3. N R S U A |
| 4. Stuffy ears or sinuses? | 4. N R S U A |
| 5. Itching in ear canals? | 5. N R S U A |
| 6. Dizzy/unbalanced sensations? | 6. N R S U A |

NECK OR SHOULDERS:

- | | |
|--------------------------------------|--------------|
| 1. Limited neck motion? | 1. N R S U A |
| 2. Stiffness? | 2. N R S U A |
| 3. Pain or aching? | 3. N R S U A |
| 4. Arm/finger numbness/tingling/pain | 4. N R S U A |
| 5. Upper or lower back pain? | 5. N R S U A |
| 6. Muscle spasm or cramping? | 6. N R S U A |

SELF-IMAGE AND COPING:

- | | |
|--|--------------|
| 1. Negative feelings of self? | 1. N R S U A |
| 2. Fear of negative reactions of others? | 2. N R S U A |
| 3. Changes in social roles? | 3. N R S U A |
| 4. Insomnia? | 4. N R S U A |
| 5. Anxiety? | 5. N R S U A |
| 6. Depression? | 6. N R S U A |
| 7. Fatigue? | 7. N R S U A |
| 8. Rejection by loved ones? | 8. N R S U A |

OUT OF TOWN PATIENTS,

PLEASE SEND SHEET WEEKLY TO:

- **FAX 480-990-2311**
- **TEXT 480-845-0266**
- **EMAIL frontoffice@azcld.com**