

Myofascial Pain Examination

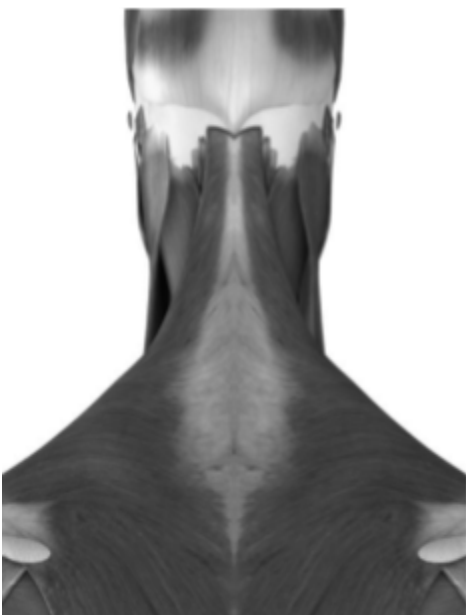
Patient Name:	Date:	Doctor:
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TMJ Examination

1. Does your Jaw open normal, click, or lock open or shut? <div style="text-align: right; padding-right: 10px;">Left:</div>	Right or Left
2. Do you have pain in/on the joint itself?	Mild, Moderate or Severe
3. Does your Jaw Make any sounds?	Click, Pop

Muscle Pain with Palpation Examination

Right		Left
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Trapezius	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Sternocleidomastoid	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Splenius Capitus	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Superficial Masseter	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Deep Masseter	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Anterior Temporalis	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Middle Temporalis	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer
<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer	Posterior Temporalis	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+ <input type="checkbox"/> Refer



Mandibular Range of Motion

Jaw opening direction – circle	<input type="radio"/> Straight <input type="radio"/> To the side, Right or Left (circle) <input type="radio"/> Comes back to center, yes or no
Unassisted opening in mm	_____ mm, Pain? Yes or No
Maximum opening in mm	_____ mm, Pain? Yes or No
Right lateral excursion in mm	_____ mm, Pain? Yes or No
Left lateral excursion in mm	_____ mm, Pain? Yes or No
Protrusion in mm	_____ mm, Pain? Yes or No

Recommendations

Injections	<input type="checkbox"/> Botox Injections <input type="checkbox"/> Nerve Block <input type="checkbox"/> TMJ
Splint/Orthotic	<input type="checkbox"/> Type:
Self-Care	<input type="checkbox"/> Exercise Diary <input type="checkbox"/> Oral Habits <input type="checkbox"/> Pain
Medication	<input type="checkbox"/> Anti-Inflammatory Chloride Spray <input type="checkbox"/> Muscle Relaxant <input type="checkbox"/> Ethyl
Imaging	<input type="checkbox"/> Refer <input type="checkbox"/> Other:
Physical Therapy	<input type="checkbox"/> Refer to evaluate and treat <input type="checkbox"/> Exercise: <input type="checkbox"/> Postural <input type="checkbox"/> 6 by 6 <input type="checkbox"/> Stretching <input type="checkbox"/> Relaxation
Behavioral Health	<input type="checkbox"/> Refer <input type="checkbox"/> Other:
TMJ Surgery	<input type="checkbox"/> Refer <input type="checkbox"/> Other:

<p>Diagnosis (check all that apply)</p> <p><u>R</u> <u>L</u> <u>Joint Disorders</u></p> <input type="checkbox"/> <input type="checkbox"/> TMJ Ankylosis and Adhesions M26.61 <input type="checkbox"/> <input type="checkbox"/> TMJ Arthralgia and Inflammation M26.62 <input type="checkbox"/> <input type="checkbox"/> TMJ Disc Disorder (reducing) M26.63 <input type="checkbox"/> <input type="checkbox"/> TMJ Disc Disorder (non-reducing) M26.63 <input type="checkbox"/> <input type="checkbox"/> TMJ Dislocated Jaw, closed lock S03.0XXA <input type="checkbox"/> <input type="checkbox"/> TMJ Dislocated Jaw, open lock S03.0XXA <input type="checkbox"/> <input type="checkbox"/> TMJ Osteoarthritis, local & 1° M19.91 <input type="checkbox"/> <input type="checkbox"/> TMJ Rheumatoid Arthritis M15.0 <input type="checkbox"/> <input type="checkbox"/> TMJ Traumatic Arthropathy M12.58	<p><u>Muscle Disorders</u></p> <input type="checkbox"/> Muscle Spasm M62.40 <input type="checkbox"/> Myofascial Pain: Masticatory M60.9 <input type="checkbox"/> Myofascial Pain: Cervical M60.9 <input type="checkbox"/> Fibromyalgia/Chronic fatigue M79.7 <p><u>Headache</u></p> <input type="checkbox"/> Migraine with Aura G43.109 <input type="checkbox"/> Migraine without Aura G43.009 <input type="checkbox"/> Cluster Headache G43.811 <input type="checkbox"/> Tension-Type Headache G44.209	<p><u>Neuropathic</u></p> <input type="checkbox"/> Trigeminal Neuralgia G50.0 <input type="checkbox"/> Atypical Face Pain G50.1 <input type="checkbox"/> Glossodynia/ Burning Mouth K14.6 <p><u>Other</u></p> <input type="checkbox"/> Orofacial Dyskinesia G24.4 <input type="checkbox"/> Bruxism/Teeth Grinding F45.8 <input type="checkbox"/> Psychological Factors F54 <input type="checkbox"/> Anomalies of Jaw Size M26.00
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<input type="checkbox"/> <input type="checkbox"/> TMJ Strain/Sprain from Overuse S03.4XXA	<input type="checkbox"/> Rebound/Transformed R51	<input type="checkbox"/> List:
<input type="checkbox"/> <input type="checkbox"/> TMJ Implant Failure M26.61		
<input type="checkbox"/> <input type="checkbox"/> TMJ Tumor Benign D16.5		
<input type="checkbox"/> <input type="checkbox"/> TMJ Tumor Other: _____		
Referral		
Doctor:	Date:	