Dr. Drew Markham Dentistry

Name:_____

Date:_____

Please fill out the following chart to reflect your current experience of the following symptoms.

SCORING FROM 0 – 5: 0=none, 5=extreme

HEADACHES	___ LEFT	___ RIGHT
TMJ PAIN	___ LEFT	___ RIGHT
TMJ NOISE	___ LEFT	___ RIGHT
LIMITED OPENING	___ LEFT	___ RIGHT
EAR CONGESTION	___ LEFT	___ RIGHT
RINGING IN EARS	___ LEFT	___ RIGHT
FACIAL PAIN	___ LEFT	___ RIGHT
NECK PAIN	___ LEFT	___ RIGHT
FINGER NUMBNESS	___ LEFT	___ RIGHT
PAIN IN TEMPLES	___ LEFT	___ RIGHT
VERTIGO/DIZZINESS	___	
GRINDING	___	
CLENCHING	___	