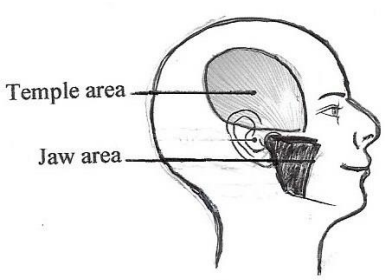
Initial Doctor Questionnaire



DO NOT enter the patient in this study**:**

- if <u>your patient</u> does **not** have a TMD **pain** diagnosis
- if <u>your patient</u> does **not** need treatment at this time
- if <u>you</u> are **not** going to treat the patient
- if <u>you</u> are going to **refer** the patient *and* **not** treat them at all

Please complete this questionnaire **after** you have **presented your treatment plan** to your patient.

1. Did the patient have any of the following complaints?

TMJ noise (e.g., popping, clicking)	☐ Yes ☐ No
Jaw stiffness or fatigue	☐ Yes ☐ No
Jaw pain	☐ Yes ☐ No
Temple pain	☐ Yes ☐ No
Headache	☐ Yes ☐ No
Ear pain	☐ Yes ☐ No
Limited opening	☐ Yes ☐ No
TMJ catching or locking closed	☐ Yes ☐ No
Jaw locking wide open	☐ Yes ☐ No
Change in occlusion	☐ Yes ☐ No
Other (please describe):	☐ Yes ☐ No

2. What makes your patient's **jaw or temple** pain **WORSE?**

If you did not assess this, then check the box to the right and **SKIP** to the next question.	☐
If you asked this question, then **complete** the following:	
Jaw movement	☐ Yes ☐ No ☐ Did not ask
Eating/chewing	☐ Yes ☐ No ☐ Did not ask
Talking	☐ Yes ☐ No ☐ Did not ask
Mouth guard/Bite splint	☐ Yes ☐ No ☐ Did not ask
Oral habits	☐ Yes ☐ No ☐ Did not ask
Gum chewing	☐ Yes ☐ No ☐ Did not ask
Caffeine	☐ Yes ☐ No ☐ Did not ask
Sleep	☐ Yes ☐ No ☐ Did not ask
Yawning or opening wide such as with eating	☐ Yes ☐ No ☐ Did not ask
Prolonged mouth opening or opening too wide during dental treatment	☐ Yes ☐ No ☐ Did not ask
Too much pressure on the jaw during dental treatment	☐ Yes ☐ No ☐ Did not ask
Work (including working at home)	☐ Yes ☐ No ☐ Did not ask
Weather changes	☐ Yes ☐ No ☐ Did not ask
Stress	☐ Yes ☐ No ☐ Did not ask
Depression	☐ Yes ☐ No ☐ Did not ask
Anxiety	☐ Yes ☐ No ☐ Did not ask
Kissing	☐ Yes ☐ No ☐ Did not ask
Intimate sexual behaviors	☐ Yes ☐ No ☐ Did not ask
Other (describe):	☐ Yes ☐ No ☐ Did not ask

3. What makes your patient's **jaw or temple** pain **BETTER?**

If you did not assess this, then check the box to the right and **SKIP** to the next question.	☐
If you asked, then **complete** the following:	
Cold/Ice and/or heat	☐ Yes ☐ No ☐ Did not ask
Relaxing	☐ Yes ☐ No ☐ Did not ask
Soft diet	☐ Yes ☐ No ☐ Did not ask
Over-the-counter pain medication	☐ Yes ☐ No ☐ Did not ask
Prescription pain medication	☐ Yes ☐ No ☐ Did not ask
Over-the-counter mouth guard/bite splint	☐ Yes ☐ No ☐ Did not ask
Mouth guard/bite splint from dentist	☐ Yes ☐ No ☐ Did not ask
Other (describe):	☐ Yes ☐ No ☐ Did not ask

EXAM FINDINGS

4. In your opinion, was the range of motion of the jaw within normal limits for this patient?

   ☐ Yes ☐ No ☐ Check this box if not assessed and **SKIP** to the next question.

5. Did your patient report pain in their TMJs or jaw muscles with range of motion?

   ☐ Yes ☐ No ☐ Check this box if not assessed and **SKIP** to the next question.

6. Where did your patient report pain with palpation?

If you did not assess this, then check the box to the right and **SKIP** to the next question.	☐
If you assessed this, then **complete** the following:	

Right side		**Left side**	
Temporalis muscle	☐ Yes ☐ No	Temporalis muscle	☐ Yes ☐ No
Masseter muscle	☐ Yes ☐ No	Masseter muscle	☐ Yes ☐ No
TMJ	☐ Yes ☐ No	TMJ	☐ Yes ☐ No
Optional List other sites:	☐ Yes ☐ No	**Optional** List other sites:	☐ Yes ☐ No

7. Did range of motion **or** palpation provoke or replicate their pain complaint in any of the following sites?

If you did not assess this, then check the box to the right and **SKIP** to the next question.	☐
If you assessed this, then **complete** the following:	
Jaw muscle(s)	☐ Yes ☐ No
Right TMJ	☐ Yes ☐ No
Left TMJ	☐ Yes ☐ No
Headache in the temple area	☐ Yes ☐ No

8. What noise(s) did you detect?

If you did not assess this, then check the box to the right and **SKIP** to the next question.	☐
If you assessed this, then **complete** the following:	

Right side		**Left side**	
Clicking/popping	☐ Yes ☐ No	Clicking/popping	☐ Yes ☐ No
Crepitus (e,g., crunching, grinding, grating)	☐ Yes ☐ No	Crepitus (e.g., crunching, grinding, grating)	☐ Yes ☐ No
No noise detected	☐	No noise detected	☐

9. What **radiographs, imaging studies, or additional diagnostic testing** have been taken, ordered or referred to further assess your patient?

If you did not do any further testing then check the box to the right and **SKIP** to next question.	☐
If you did further testing, then **complete** the following:	
Panoramic radiograph	☐ Yes ☐ No
TMJ cone beam computerized tomography (CBCT)	☐ Yes ☐ No
TMJ medical computerized tomography (CT)	☐ Yes ☐ No
TMJ magnetic resonance imaging (MRI)	☐ Yes ☐ No
Myomonitor-type device with TENS	☐ Yes ☐ No
Home sleep test or polysomnogram	☐ Yes ☐ No
Other (describe):	

10. What are the patient's TMD diagnoses?

Diagnoses **Please complete this to the best of your ability**	
Right TMJ pain (arthralgia)	☐ Yes ☐ No
Left TMJ pain (arthralgia)	☐ Yes ☐ No
Masticatory muscle pain (myalgia)	☐ Yes ☐ No
Masticatory muscle pain with referral (myofascial pain)	☐ Yes ☐ No
Headache related to TMD pain	☐ Yes ☐ No
TMJ disorder with clicking/popping noises (disc displacement with reduction)	☐ Yes ☐ No
TMJ disorder with crepitus noises (degenerative joint disease/osteoarthritis)	☐ Yes ☐ No
TMJ disorder with intermittent limited opening (disc displacement with reduction with intermittent locking)	☐ Yes ☐ No
TMJ disorder with persistent limited opening (disc displacement without reduction with limited opening)	☐ Yes ☐ No
TMJ disorder with locking wide open (dislocation)	☐ Yes ☐ No
Other (describe):	☐ Yes ☐ No

TREATMENT RECOMMENDATION(S)

11. What **self-care** did you recommend?

If you did not recommend **self-care**, then check the box to the right and **SKIP** to the next question. ☐	
If you recommended this, then **complete** the following:	
Self-care	**Recommended**
Apply heat or ice	☐ Yes ☐ No
Eat a soft diet	☐ Yes ☐ No
Chew food on both sides	☐ Yes ☐ No
Keep your teeth apart	☐ Yes ☐ No
Relax your jaw (muscles)	☐ Yes ☐ No
Avoid oral habits (e.g., clenching or grinding teeth)	☐ Yes ☐ No
Avoid chewing gum	☐ Yes ☐ No
Reduce caffeine intake	☐ Yes ☐ No
Other (*please specify*):	☐ Yes ☐ No

12. What over-the-counter or prescription **medication(s)** did you recommend?

If you did not recommend **medication,** then check the box to the right and **SKIP** to the next question. ☐	
If you recommended this, then **complete** the following:	
Medications	**Recommended**
Over-the-counter analgesics	☐ Yes ☐ No
Prescription NSAIDs	☐ Yes ☐ No
Prescription narcotics	☐ Yes ☐ No
Prescription cannabinoids	☐ Yes ☐ No
Muscle relaxant	☐ Yes ☐ No
Tricyclic antidepressants	☐ Yes ☐ No
Other (*please specify)*:	☐ Yes ☐ No

13. Did you recommend **ANY** type of **intra-oral appliance**?

☐ Yes ----------→ Go to next question

☐ No ----------→ **SKIP** to **question 17**.

14. Please place an "X" in the box to the right of each characteristic of your *initial* appliance therapy.

Fabrication Site (Check one)	
1. Commercial laboratory (custom made)	☐
2. Made in dental clinic (custom made)	☐
3. Over-the-counter stock appliance	☐
Appliance Material (Check one)	
4. Methyl methacrylate	☐
5. Thermoplastic	☐
6. Laminated (hard exterior shell with inner soft thermoplastic)	☐
7. Soft material	☐
8. Boil and bite (stock appliance)	☐
9. Vacuum-formed	☐
Dental Arch (Check one)	
10. Upper	☐
11. Lower	☐
12. Both	☐
Coverage (Check one)	
13. Full arch coverage	☐
14. Anterior only coverage (no teeth covered posterior to canines)	☐
15. Posterior only coverage	☐
16. Two-arch sleep apnea style appliance (mandibular anterior repositioning)	☐
17. Two-arch coverage without repositioning	☐
Jaw Position for Appliance Fabrication (Check one)	
18. Clinician guided (e.g. CR using the dentist's preferred method)	☐
19. Rest closure / Patient preferred comfortable position	☐
20. Maximum intercuspal position	☐
21. Protrusive position	☐
22. Determined by electronic instrumentation	☐
23. Determined by TMJ MRI	☐
Occlusal Contacts in the Treatment Position (Check one)	
24. Full arch (maximum number of functional cusps in occlusion on closing)	☐
25. Anterior only (includes stylus designs)	☐
26. Posterior only	☐
Excursive Contact Design (Check all that apply)	
27. Steep anterior guidance	☐
28. Shallow anterior guidance	☐
29. Flat anterior guidance	☐
30. Canine guidance	☐
31. Group function (posterior and canine)	☐
32. Canine guidance with anterior crossover	☐
33. Posterior only	☐
34. Non-working balancing contacts	☐
35. Reverse incline (repositioning appliance)	☐

15. When will your patient be wearing their appliance? **(Check all that apply).**

No specific recommendation made	☐ Yes ☐ No
When awake (excluding during eating)	☐ Yes ☐ No
When eating	☐ Yes ☐ No
During sleep	☐ Yes ☐ No

16. Please select your primary goal(s) for treatment with the above appliance.

Stabilization of the masticatory system	☐ Yes ☐ No
Recapture of displaced TMJ disc(s) during sleep only	☐ Yes ☐ No
Recapture of displaced TMJ disc(s) permanently	☐ Yes ☐ No
Relief of retrodiscal pain	☐ Yes ☐ No
Muscle relaxation ("deprogramming")	☐ Yes ☐ No
Alteration of the vertical dimension of occlusion	☐ Yes ☐ No
Stabilization of the jaw position prior to correcting the malocclusion	☐ Yes ☐ No
Management of sleep-disordered breathing	☐ Yes ☐ No
Unload the TMJ/jaw joints	☐ Yes ☐ No
Other (*please specify)*:	☐ Yes ☐ No

17. What **additional treatment(s)** did you recommend for their jaw or temple pain?

If you did not recommend any additional treatment, then check the box to the right and **SKIP** to the next question.	☐
If you recommended additional treatment, then **complete** the following:	

Additional Treatments	**Recommended**
Herbs or supplements for pain	☐ Yes ☐ No
Jaw exercises	☐ Yes ☐ No
Self massage of jaw or temple	☐ Yes ☐ No
Massage therapy	☐ Yes ☐ No
Physical therapy	☐ Yes ☐ No
Chiropractic treatment	☐ Yes ☐ No
Psychological treatment (e.g., biofeedback, relaxation techniques)	☐ Yes ☐ No
Low level laser therapy	☐ Yes ☐ No
Trigger point injections	☐ Yes ☐ No
Botox injections	☐ Yes ☐ No
Acupuncture	☐ Yes ☐ No
Occlusal adjustment (bite adjustment)	☐ Yes ☐ No
Orthodontics for occlusal stabilization	☐ Yes ☐ No
Restorative dentistry for occlusal stabilization (e.g., crowns)	☐ Yes ☐ No
Full mouth reconstruction for occlusal stabilization	☐ Yes ☐ No
Jaw surgery (Orthognathic surgery)	☐ Yes ☐ No
TMJ arthrocentesis	☐ Yes ☐ No
TMJ arthroscopic surgery	☐ Yes ☐ No
TMJ open joint surgery (e.g., disc repair)	☐ Yes ☐ No
Other (*please specify*):	☐ Yes ☐ No

18. Who in your office provided the treatment recommendations to your patient?

(Check all that apply)

☐ Dentist

☐ Hygienist

☐ Dental assistant

☐ Other (describe):

19. Please indicate any difficulty you expect in implementing treatment.

Financial cost to the patient	☐ Yes ☐ No
Lack of insurance coverage	☐ Yes ☐ No
Side effects of the treatment	☐ Yes ☐ No
Patient's compliance	☐ Yes ☐ No
Difficult or time consuming for the patient	☐ Yes ☐ No
Treatment was not the patient's preference	☐ Yes ☐ No
Treatment may not be effective	☐ Yes ☐ No
Treatment may only have a short-term effect	☐ Yes ☐ No
Time consuming for you to implement	☐ Yes ☐ No
Treatment is difficult for you to implement	☐ Yes ☐ No
Minimal experience or training doing treatment	☐ Yes ☐ No
Availability of physical therapist for referral	☐ Yes ☐ No
Availability of psychologist for referral	☐ Yes ☐ No
Other (*please specify*):	☐ Yes ☐ No

20. Did the patient report having insurance coverage for their treatment?

☐ Yes ----→ Go to next question

☐ No ----→ **SKIP to question 22**

☐ Did not ask **SKIP to question 22**

21. If yes, what type of insurance coverage did your patient report having? **(Check one)**

☐ Dental ☐ Medical ☐ Both Dental and Medical

☐ Patient did not know

22. Did the patient's finances prevent them from accepting any of your recommended treatment options**? (Check one)**

☐ Yes ☐ No

☐ You did not ask ☐ Patient did not know

The following questions ask **your opinion** about the treatment plan that you recommended to your patient:

23. How much will the treatment **relieve** your patient's pain?

No relief										**Complete relief**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

24. How much will the treatment **improve** your patient's ability to use their jaw?

No improvement										**Complete improvement**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

25. How **satisfied** will your patient be with the treatment?

Not at all satisfied										**Very satisfied**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

26. How **easy** will it be for your patient to follow your treatment recommendation(s)?

Not at all easy										**Very easy**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

27. How well did your patient **understand** your treatment recommendation(s)?

Not at all well										**Very well**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Thank you - Your time and expertise are appreciated!