

Member Name: \_\_\_\_\_ CareSource ID#: \_\_\_\_\_

Health Partner Name: \_\_\_\_\_ Location: \_\_\_\_\_

**Clinical Examination****Palpation Over Joint Area****Perceptible Click on Palpation:****Right** None Slight Moderate Severe**Left** None Slight Moderate Severe**Perceptible Crepitus on Palpation:****Right** None Slight Moderate Severe**Left** None Slight Moderate Severe**Maximum Comfortable Opening**

Non Assisted \_\_\_mm      Assisted \_\_\_mm

**Deviation of Mandibular Midline On Opening**

None\_\_\_    Direction\_\_\_    Amount\_\_\_mm

**Muscle Tension and/or Pain Response**

	<b>RIGHT</b>	<b>LEFT</b>
Masseter	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Temporalis Tendon	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suprahyoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stylohyoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lateral Pterygoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Palpation in External Auditory Meatus****Perceptible Click on Palpation:****Right** None Slight Moderate Severe**Left** None Slight Moderate Severe**Perceptible Crepitus on Palpation:****Right** None Slight Moderate Severe**Left** None Slight Moderate Severe**Range of Motion**

Opening \_\_\_\_\_mm

Right Lateral \_\_\_\_\_mm

Left Lateral \_\_\_\_\_mm

**TMD History**History of TMD Trauma Yes NoHistory of TMD Treatment Yes No**What brings on the pain?** \_\_\_\_\_**Intensity? (Mild, Moderate, Severe)** \_\_\_\_\_**Duration?** \_\_\_\_\_**What relieves the pain?** \_\_\_\_\_