

TMJ SYMPTOM INTENSITY SCALE (SIS)

Name: _____ Date: _____ Date of birth /age: _____ / _____

Please indicate the intensity of your symptoms as follows:

- Circle the number on the scale to indicate your most usual symptom level
- Draw an X through the number to indicate your most severe symptom level.

1. Jaw Pain	No Pain	0 1 2 3 4 5 6 7 8 9 10	Most intense pain
2. Painful jaw clicking	No Pain	0 1 2 3 4 5 6 7 8 9 10	Most intense pain
3. Jaw locking	No pain to open mouth	0 1 2 3 4 5 6 7 8 9 10	Can barely open mouth
4. Headaches	No Pain	0 1 2 3 4 5 6 7 8 9 10	Most intense pain
5. Neck and/or upper shoulder muscle pain	No Pain	0 1 2 3 4 5 6 7 8 9 10	Most intense pain
6. Dizziness	No dizziness	0 1 2 3 4 5 6 7 8 9 10	Most intense dizziness
7. Ringing in the ears	No ringing	0 1 2 3 4 5 6 7 8 9 10	Most intense ringing

TMJ SYMPTOM FREQUENCY SCALE (SFS)

Please indicate the frequency of your symptoms as follows:

- Circle the number on the scale to indicate how often you experience the following symptoms

1. Jaw Pain	Never	0 1 2 3 4 5 6 7 8 9 10	100% of the time
2. Painful jaw clicking	Never	0 1 2 3 4 5 6 7 8 9 10	100% of the time
3. Jaw locking	Never	0 1 2 3 4 5 6 7 8 9 10	100% of the time
4. Headaches	Never	0 1 2 3 4 5 6 7 8 9 10	100% of the time
5. Neck pain and/or upper shoulder muscle pain	Never	0 1 2 3 4 5 6 7 8 9 10	100% of the time
6. Dizziness	Never	0 1 2 3 4 5 6 7 8 9 10	100% of the time
7. Ringing in the ears	Never	0 1 2 3 4 5 6 7 8 9 10	100% of the time

↓ FOR OFFICE USE ONLY ↓

Scoring Summary Chart

	Initial - Date _____	1 st Re-√ _____	2 nd Re-√ _____	3 rd Re-√ _____
TMJ Disability Index				
TMJ SIS (usual/max.)	/	/	/	/
TMJ SFS				

Comments: _____

Patient's signature _____ Date _____