

## TMD 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

## TMD 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 <sup>st</sup> Re-√ _____	2 <sup>nd</sup> Re-√ _____	3 <sup>rd</sup> Re-√ _____
TMD Disability Index				
TMD SIS (usual/max.)	/	/	/	/
TMD SFS				

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_