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

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↓ FOR OFFICE USE ONLY ↓

Scoring Summary Chart

	Initial - Date_____	**1st Re-√ __________**	**2nd Re-√___________**	**3rd Re-√__________**
TMD Disability Index				
TMD SIS (usual/max.)	/	/	/	/
TMD SFS				

Comments: ____

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Patient's signature _______________________________________ Date________________