TMD Disability Index

Name_____ M/F__ Age____ Date_____ Score_____

Please check the statement that best pertains to you (not necessarily exactly) in each of the following categories.

Section 1 – Communication (talking).

☐ I can talk as much as I want without pain, fatigue or discomfort.
☐ I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
☐ I can't talk as much as I want because of pain, fatigue and/or discomfort
☐ I can't talk much at all because of pain, fatigue and/or discomfort.
☐ Pain prevents me from talking at all.

Section 2 - Normal living activities (brushing teeth/flossing).

☐ I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
☐ I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/ discomfort, jaw tiredness results.
☐ I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
☐ I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
☐ I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

Section 3 – Normal living activities (eating, chewing).

☐ I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
☐ I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
☐ I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
☐ I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
☐ I must stay on a liquid diet because of pain and/or restricted opening.

Section 4 – Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, and recreation, etc.).

☐ I am enjoying a normal social life and/or recreational activities without restriction.
☐ I participate in normal social life and/or recreational activities but pain/discomfort is increased.
☐ The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instrument, singing).
☐ I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
☐ I have practically no social life because of pain.

Section 5 – Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide).

☐ I can yawn in a normal fashion, painlessly.
☐ I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
☐ I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
☐ Yawning and opening my mouth wide are somewhat restricted by pain.
☐ I cannot yawn or open my mouth more than two finger widths (2.8-3.2 cm) or, if I can, it always causes greater than moderate pain.

Section 6 – Sexual function (including kissing, hugging, and/all sexual activities to which you are accustomed).
☐ Not applicable.
☐ I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face, or jaw pain.
☐ I am able to engage in all my customary sexual activities and expressions, but it sometimes causes some headache, face, or jaw pain, or jaw fatigue.
☐ I am able to engage in all my customary sexual activities and expressions, but it usually causes enough headache, face, or jaw pain to markedly interfere with my enjoyment, willingness, and satisfaction.
☐ I must limit my customary sexual activities and expressions because of headache, face, or jaw pain or limited mouth opening.
☐ I abstain from almost all sexual activities and expression because of the head, face, or jaw pain it causes.

Section 7 – Sleep (restful, nocturnal sleep pattern).
☐ I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
☐ I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aides.
☐ I fail to realize 6 hours restful sleep even with the use of pills.
☐ I fail to realize 4 hours restful sleep even with the use of pills.
☐ I fail to realize 2 hours restful sleep even with the use of pills.

Section 8 – Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatment, oral orthotics(eg, splints, mouthpieces), ice/health, etc.
☐ I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
☐ I can completely control my pain with some form of treatment.
☐ I get partial, but significant, relief through some form of treatment.
☐ I don't get "a lot of" relief from any form of treatment.
☐ There is no form of treatment that helps enough to make me want to continue.

Section 9 – Tinnitus, or ringing in the ear(s).
☐ I do not experience ringing in my ear(s).
☐ I experience ringing in my ears(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
☐ I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
☐ I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
☐ I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

Section 10 – Dizziness (lightheaded, spinning and/or balance disturbance).
☐ I do not experience dizziness.
☐ I experience dizziness, but it does not interfere with my daily activities.
☐ I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.

☐ I experience dizziness, which causes a marked impairment in the performance of my daily activities.
☐ I experience dizziness, which is incapacitating.

Yes	No	
___	___	Do you have any history of trauma to your face or jaw, or have any scars on your chin?
___	___	Do you wear a nightguard or any other dental appliance?
___	___	Have you had any previous treatment to your jaw, including orthodontia?
___	___	Do you chew gum, bite your nails, find yourself with your teeth together, or clench at night?
___	___	Do you have more jaw or facial pain in the morning?
___	___	Are you depressed, currently seeing, or have seen a counselor in the past?