

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## CRANIO-MANDIBULAR VISUAL ASSESSMENT

Please check off any symptoms you are experiencing below. You can either print this page and fill it out by hand or check the active fields online using Adobe Acrobat.

### HEAD PAIN, HEADACHE

- Forehead
- Temples
- Migraine
- Sinus
- Shooting pain up and down back of head
- Hair and/or scalp painful to touch

### OTHER

- Postural problems
- Tingling in fingertips
- Thermal sensitivity to hot or cold
- Nervousness or insomnia

### EARS

- Buzzing or ringing
- Decreased hearing
- Ear pain or earache but no infection
- Clogged, itchy ears
- Vertigo and dizziness

### EYES

- Pain behind eyes
- Bloodshot eyes
- Bulged-out eyes
- Sensitive to sunlight

### MOUTH

- Discomfort
- Limited opening of mouth
- Inability to open smoothly
- Difficulty chewing
- Jaw deviates to one side when opening
- Locks shut or open
- Can't find comfortable bite

### TEETH

- Clenching or grinding at night
- Looseness and soreness of back teeth
- Tender or sensitive teeth

### THROAT

- Swallowing difficulties
- Laryngitis
- Sore throat with no infection
- Voice irregularities or changes
- Frequent coughing or constant clearing of throat
- Feeling of foreign object in throat constantly

### JAW

- Clicking or popping jaw joints
- TMJ pain
- Grating sounds
- Pain in cheek muscles
- Uncontrollable jaw and/or tongue movement

### NECK

- Lack of mobility and stiffness
- Neck pain
- Tired, sore muscles
- Shoulder aches and backaches
- Arm and finger numbness and/or pain

