

# OCCLUSION & TMJ ANALYSIS

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**PATIENT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Please answer by checking, circling and/or describing all that apply:**

CIRCLE

**YES NO**

- \_\_\_\_\_ 1) Do you have frequent headaches? Migrains? \_\_\_\_\_ 1-10? \_\_\_\_\_
- \_\_\_\_\_ 2) Do you have pain in or around the jaw joint? 1-10? \_\_\_\_\_ L R  
When did you first notice the jaw pain? \_\_\_\_\_
- \_\_\_\_\_ 3) Has the pain recently become more severe?
- \_\_\_\_\_ 4) When is the pain worse? Mornings Evenings At Meals
- \_\_\_\_\_ 5) Do you have tired jaw muscles? Mornings Evenings
- \_\_\_\_\_ 6) Do you have tooth sensitivity to: Cold?\_\_ Air?\_\_ Chewing?\_\_ Tooth/Teeth?\_\_\_\_\_
- \_\_\_\_\_ 7) Do you have clicking, popping, or grating noises in your jaw joint? L R  
When did you first notice the noise? \_\_\_\_\_
- \_\_\_\_\_ 8) Does your jaw problem interfere with your normal activities?
- \_\_\_\_\_ 9) Have you had treatment(s) for this problem? When? \_\_\_\_\_ Where? \_\_\_\_\_
- \_\_\_\_\_ 10) Are you taking, or have you taken, medication for this problem?
- \_\_\_\_\_ 11) Are you taking antidepressants or any medication that may affect muscle activity or cause dry mouth?
- \_\_\_\_\_ 12) Have you ever had a severe blow or trauma to the head, neck or jaw?  
Explain: \_\_\_\_\_
- \_\_\_\_\_ 13) Do you have difficulty chewing? This is a result of: Pain in joint Pain in teeth  
Limited opening Other (specify): \_\_\_\_\_
- \_\_\_\_\_ 14) Has your mouth ever locked open or closed? When? \_\_\_\_\_
- \_\_\_\_\_ 15) Are you aware of: clenching and/or: grinding your teeth? (Please circle)
- \_\_\_\_\_ 16) Do you think nervous tension seems to affect this problem?
- \_\_\_\_\_ 17) Have there been recent changes in your lifestyle or other stressful events?
- \_\_\_\_\_ 18) Have you had problems with other joints? Pain? \_\_\_\_\_
- \_\_\_\_\_ 19) Have you ever felt or do you feel like your bite is changing? Y N When?\_\_\_\_\_
- \_\_\_\_\_ 20) What are your main Goals for "Occlusal" & TMJ treatment? \_\_\_\_\_

**INITIAL EXAM**

**1ST FOLLOW UP**

**2ND FOLLOW UP**

## CLINICAL EVALUATION

**DATE:** \_\_\_\_\_

1. Load Test Pain \_\_\_\_\_ 2. Initial Contact (Mouth) \_\_\_\_\_ 3. Occlusal Slide \_\_\_\_\_ Take Bite \_\_\_\_\_
4. Ant. Guidance \_\_\_\_\_ Canine Guide. R: \_\_\_\_\_ L: \_\_\_\_\_
5. Max Opening \_\_\_\_\_ Lat. R: \_\_\_\_\_ L: \_\_\_\_\_ Pain On: Opening: \_\_\_\_\_ R: \_\_\_\_\_ L: \_\_\_\_\_
6. Fremitus:/Mobility 2+ \_\_\_\_\_ 7. CDHypersensitivity (CDH) \_\_\_\_\_
8. TMJ Noise R: \_\_\_\_\_ L: \_\_\_\_\_
9. Envelope Violation \_\_\_\_\_ 10. Cross Bite \_\_\_\_\_ Open Bite \_\_\_\_\_
11. Parafunction: Brux Clench 12. Angle Bite Class: I IID1 IID2 III

## MOUNTED CAST EVALUATION / Specify Tooth, Surface, Location

**CHECK BITE first** CR Interf: \_\_\_\_\_ Lat. Interf: \_\_\_\_\_ Occlusal Plane: \_\_\_\_\_  
Severe Wear: Abfraction: Is It Close Enough? Wax-Up Needed?

## TRIAL OCCLUSAL EQUILIBRATION (Specify tooth, surface, location)

Initial Incisal Pin Setting: \_\_\_\_\_ Final Pin Setting: \_\_\_\_\_ Bite Close? \_\_\_\_\_  
Teeth Needing Plasty: \_\_\_\_\_  
Teeth Needing Restoration: \_\_\_\_\_

**DIAGNOSIS:** Dawson Class I II III IV

**TREATMENT**
