

**PATIENT TMJ PROGRESS REPORT**

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Name Deb Waylan

Date 1-16-07

PATIENT: List any symptoms since your last visit that you want to bring to our attention:

**DEGREE OF COMFORT**

Indicate your current degree of comfort or pain relief by circling the corresponding number.

**CHIEF COMPLAINTS**

	No Pain	Mild	Moderate	Severe	Worse Possible
<input type="checkbox"/> TMJ clicking/grating	10	(9) 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> TMJ locking/stiffness	10	(9) 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Inability to open mouth	(10)	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Mouth doesn't open straight	(10)	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Pain when eating/chewing	10	9 (8) 7 6	5 4	3 2 1	0
<input type="checkbox"/> Pain in jaw or jaw joint	10	9 8 7 (6)	5 4	3 2 1	0
<input type="checkbox"/> Unstable bite	(10)	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Headache	10	(9) 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Face Pain	(10)	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Neck Pain	10	(9) 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Ear Pain/stiffness	10	9 8 7 (6)	5 4	3 2 1	0
<input type="checkbox"/> Ringing in ears	10	9 8 (7) 6	5 4	3 2 1	0
<input type="checkbox"/> Difficulty swallowing	(10)	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Throat pain	(10)	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Face muscle fatigue	(10)	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Other _____	10	9 8 7 6	5 4	3 2 1	0
<input type="checkbox"/> Other _____	10	9 8 7 6	5 4	3 2 1	0

Total improvement since beginning of treatment 90 %

Debra B. Waylan  
Patient Signature