



**Berryville**  
Physical Therapy and Wellness

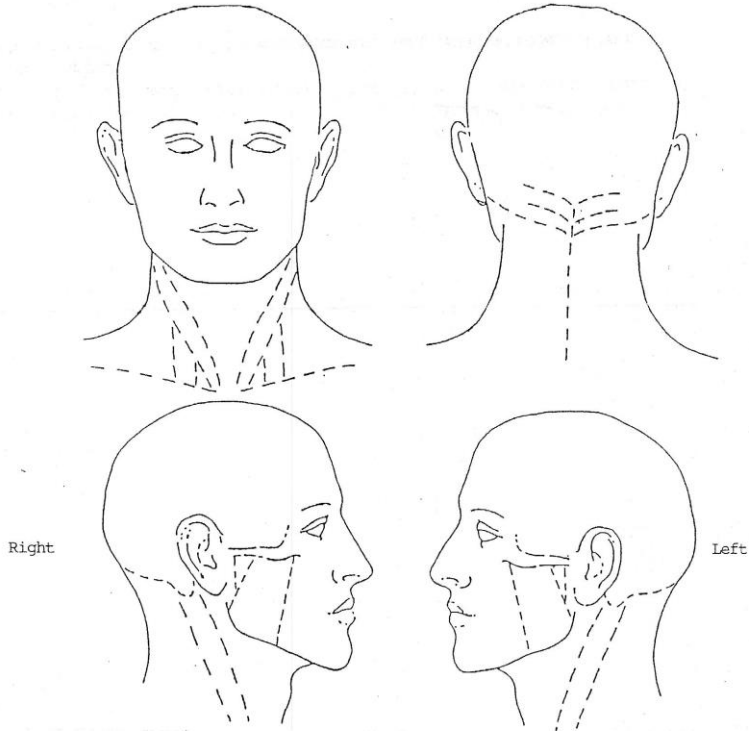
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## TMJ DISCOMFORT SCALE

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

Date \_\_\_\_\_

PLEASE  
SHADE  
IN  
THE  
AREAS  
YOU  
HAVE  
DISCOMFORT



Please indicate pain range by circling your **high** and **low** levels experienced within the last month.

10	<b>EMERGENCY SITUATION</b> (i.e. having to go to the hospital)
9	<b>INTENSE</b>
8	May require frequent use of prescription pain medications, anti-inflammatory and/or muscle relaxants. Activity may be very limited.
7	
6	<b>MODERATE</b>
5	Possible use of muscle relaxants, prescription or over-the-counter pain medications. Activity may be limited, but functional for family, work, and social roles.
4	
3	<b>LOW</b>
2	Little or no pain medications. Normal levels of activity, except heavy types.
1	
0	<b>NO PAIN</b>

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