MARVIX AI

SAMPLE TMJ DISORDER ASSESSMENT SOAP NOTE

TMJ DISC DISPLACEMENT + MYOFASCIAL PAIN — BRUXISM-DRIVEN

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Diana C. Morrison

DATE OF SERVICE
05/06/2026

DOB
09/04/1973

PROVIDER
Dr. Nathaniel Park, DDS, MD — Oral Medicine / Orofacial Pain

AGE / SEX
52 / Female

MRN / PATIENT ID
TMJ-2026-0188

CREDENTIALS
DDS, MD, Diplomate ABOM

VISIT TYPE
TMJ Disorder Assessment — New Patient

REFERRAL SOURCE
Dr. Patricia Walsh, DDS — General Dentistry

DENTAL PROVIDER / PCP
Dr. Patricia Walsh, DDS; Dr. Susan Kim, MD — Internal Medicine

REASON FOR REFERRAL
Right-sided TMJ pain and clicking x18 months, progressive jaw locking episodes, nocturnal bruxism, occlusal guard prescribed but poorly tolerated, now with limited mouth opening — referred for orofacial pain evaluation and management.

CC CHIEF COMPLAINT

2 PRIMARY TMJ / JAW CONCERN

> *'My jaw has been clicking and hurting on the right side for over a year. For the past 6 weeks it started locking — I wake up in the morning and can't open my mouth all the way. It scares me every morning. And I grind my teeth so badly my husband started sleeping in another room because of the noise.'*

- **Duration of clicking:** 18 months.
- **Duration of locking episodes:** 6 weeks.
- **Duration of current pain:** progressive over 18 months, significantly worsened in the past 6 weeks coinciding with the onset of locking.

The onset of locking is a clinically important event — it suggests disc displacement has progressed from reducible to non-reducible.

S SUBJECTIVE

3 PATIENT-REPORTED TMJ SYMPTOMS & HISTORY

3a SYMPTOM ONSET, COURSE & PAIN CHARACTERISTICS

- **Onset:** Approximately 18 months ago (fall 2024) — she recalls the clicking beginning after a period of significant work stress. 'I noticed a loud click when I opened my mouth wide — it was startling.' Initially painless, then progressively painful over the following months.
- **Course:** Progressive.
  - **Phase 1 (months 1–12):** clicking on opening and closing, intermittent aching, managed with ibuprofen.
  - **Phase 2 (months 12–16):** clicking becoming louder and more consistent; pain increasing; Dr. Walsh noted wear facets at the 12-month dental visit and fabricated an occlusal night guard.
  - **Phase 3 (months 16–18):** occlusal guard poorly tolerated (causes gagging sensation, removed during the night); clicking becoming less prominent — importantly, the disappearance of clicking in the setting of progressing symptoms often signals disc displacement transitioning from reducible (with click) to non-reducible (without click — locking).
  - **Phase 4 (past 6 weeks):** morning jaw locking — 'I wake up and my mouth won't open all the way. It's stuck. I have to gently work it open.' Maximum opening currently 28 mm (she measured with a ruler out of curiosity).
- **Pain location:** Right preauricular region, right masseter, and right temporal region. Pain radiates to the right ear ('feels like an earache on the right side'). No pain on the left side.
- **Pain characteristics:** Aching and pressure-like at rest (3/10). Sharp and stabbing with wide opening, yawning, or hard chewing (6–7/10). Morning stiffness significant — 'My jaw is stiff for 30–45 minutes every morning when I wake up.' Characteristic of TMD with nocturnal parafunction.

3b JAW FUNCTION SYMPTOMS & PARAFUNCTIONAL HABITS

- **Jaw function symptoms:**
  - **Clicking:** previously prominent right-sided click on opening and closing. Now absent for the past 6 weeks — clinically significant (see assessment).
  - **Locking:** morning jaw locking x6 weeks — limited maximum opening approximately 28 mm (normal adult female approximately 40–50 mm).
  - **Crepitus:** new subtle crepitus (grating sound) on the right with slow opening over the past 2–3 weeks.
  - **Jaw deviation on opening:** yes — jaw deviates to the right on opening (toward the affected side; the mandible deviates toward the side of restricted opening).
  - **Difficulty chewing:** yes — cannot chew hard foods on the right; avoids steak, raw carrots, bagels.
  - **Yawning:** painful and limited — she suppresses yawns, which she finds uncomfortable.
- **Parafunctional habits:**
  1. **Bruxism** — confirmed by husband's report ('grinding so loud it woke him up'), by Dr. Walsh (significant wear facets on bilateral premolars and molars), and by patient self-report ('I wake up with a sore jaw and tight muscles every morning').
  2. **Clenching** — aware of clenching during the day, especially during work stress ('I catch myself with my teeth clamped together when I'm on a stressful call').
  3. Gum chewing: yes — one piece every afternoon.
  4. Nail biting: no.
  5. Jaw posturing with lower jaw forward: yes, habit noted.

3c AGGRAVATING / RELIEVING FACTORS, ASSOCIATED SYMPTOMS & PRIOR EVALUATION

- **Aggravating:** Wide mouth opening (yawning, dental work, eating large bites), hard chewing, stress, poor sleep, morning waking.
- **Relieving:** Heat pack on the right jaw (15 minutes, temporary relief), soft diet, ibuprofen 400 mg (partial relief for 3–4 hours), rest. Cold makes it worse.
- **Associated symptoms:**
  1. Right ear pain (referred otalgia from TMD — evaluated by PCP and ENT; ENT exam normal — ear canal, tympanic membrane, and hearing all normal per 2025 ENT report).
  2. Right temporal headache — 2–3 days/week, moderate (5/10), consistent with myofascial/tension headache from the temporalis muscle.
  3. Right-sided neck stiffness — monthly massage therapy provides temporary relief.
  4. Sleep disturbance — difficulty falling asleep due to anxiety and jaw tension.
  5. Anxiety — significant work-related anxiety ('I'm a hospital administrator and the stress has been relentless for 2 years').
- **Dental / orthodontic history:** Full dentition. No orthodontic treatment. Multiple composite restorations bilaterally. Night guard (soft Drufomat-type, maxillary) worn inconsistently. No extractions, no implants, and no recent dental procedures that would explain symptom onset.
- **Medical history:** Anxiety disorder (GAD) — sertraline 100 mg x3 years (partial response). Hypothyroidism — levothyroxine 88 mcg daily (well-controlled). Peri-menopausal x18 months (coincides with TMD onset). No fibromyalgia, RA, or connective tissue disease. No cervical spine pathology (2024 MRI — mild C5-6 spondylosis, no cord compression).
- **Prior TMD treatment:**
  1. Ibuprofen PRN — partial relief.
  2. Occlusal night guard (soft, maxillary) x6 months — poor adherence (removed during sleep).
  3. No physical therapy.
  4. No injections.
  5. No prior imaging of the TMJ.
- **Pertinent negatives:** No facial weakness or numbness. No unexplained weight loss. No fever or jaw swelling. No jaw infection symptoms. No rapidly progressive trismus (locking is morning-specific and improves partially through the day with jaw exercises). No dental pain or toothache as primary complaint. No systemic illness symptoms.

ROS TMJ / OROFACIAL PAIN REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Jaw pain / stiffness / locking / clicking / crepitus:** POSITIVE — right TMJ pain (3/10 rest; 6–7/10 function); morning jaw locking x6 weeks; clicking (previously); NOW crepitus (grating); morning stiffness 30–45 min
- **Pain with chewing / yawning / talking / biting:** POSITIVE — pain 6–7/10 with wide opening, yawning, hard chewing; avoiding hard foods; suppressing yawns; difficulty biting into apples or large sandwiches
- **Limited mouth opening / jaw deviation:** POSITIVE — maximum opening approximately 28 mm (restricted; normal 40–50 mm); jaw deviates RIGHT on opening (toward affected side — consistent with right disc displacement)
- **Bruxism / clenching / jaw fatigue:** POSITIVE — severe nocturnal bruxism (husband report, wear facets on exam); daytime clenching (work stress-triggered); significant morning jaw fatigue and soreness

- **Headache / facial pain / ear pain / tinnitus / dizziness:** POSITIVE — right temporal headache 2–3x/week (myofascial pattern); right referred otalgia (evaluated by ENT — ear normal); NO tinnitus; NO dizziness/vertigo
- **Dental pain / malocclusion / recent dental changes:** NEGATIVE for toothache; mild wear facets on examination (bruxism-related); no recent dental procedure precipitant
- **Fever / swelling / numbness / weakness / systemic symptoms:** NEGATIVE — no red-flag systemic symptoms; no facial numbness or weakness; no fever; no jaw swelling or fluctuance
- **Neck pain / shoulder tension / posture:** POSITIVE — right-sided neck stiffness; monthly massage therapy; desk-based work posture (forward head)
- **Sleep disturbance / stress / anxiety / chronic pain:** POSITIVE — difficulty falling asleep; significant work-related anxiety (GAD, on sertraline); chronic pain pattern x18 months

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
37.0°C — afebrile

BLOOD PRESSURE
124/78 mmHg

PAIN SCORE
3/10 rest right preauricular; 6/10 right temporal; 2/10 right neck

WEIGHT / BMI
141 lbs / BMI 23.1

5a EXTRAORAL EXAMINATION

- **General appearance:** Slight distress with jaw movement — she winces on wide opening. Forward head posture at rest. Facial symmetry intact at rest. Jaw deviates to the right on slow maximum opening — consistent with right-side restriction (disc displacement without reduction deviates the jaw toward the affected side).
- **Preauricular tenderness:** Right — 4/10 on palpation over the right TMJ. Left — none.
- **Joint sounds:** Right TMJ — crepitus (grating, irregular crackling audible with stethoscope on opening and closing); no click today, a change from prior clicking (absence of click with crepitus is consistent with non-reducible disc displacement with degenerative changes). Left TMJ — no sounds.
- **Masseter muscle:** Right — 5/10 tenderness at the body (superficial and deep heads). Left — 2/10 mild (likely compensatory overuse).
- **Temporalis muscle:** Right — 4/10 tenderness at anterior, middle, and posterior belly (explaining temporal headaches). Left — 1/10 minimal.
- **Medial pterygoid:** Right — 4/10 on intraoral palpation. Left — 1/10.
- **Lateral pterygoid (superior head):** Right — provocative pain with resisted mouth opening — positive for lateral pterygoid involvement.
- **Sternocleidomastoid:** Right — 3/10 along the posterior belly. Left — 1/10.
- **Cervical musculature:** Right-sided tenderness at upper trapezius and cervical paraspinals — consistent with secondary myofascial involvement and forward head posture.
- **Lymphadenopathy:** No cervical, submandibular, or submental lymphadenopathy.
- **Skin:** No skin lesions or rash.

5b INTRAORAL EXAMINATION

DENTITION AND OCCLUSION

Full dentition. Class I occlusion. Centric occlusion symmetric. No premature contacts identified on gross assessment.

WEAR FACETS / BRUXISM SIGNS

SIGNIFICANT bilateral wear facets on bilateral premolars and molars (maxillary and mandibular) — upper premolars and first molars show 1–2 mm of cusp tip loss, consistent with years of nocturnal bruxism. This is the most striking intraoral finding. Anterior guidance intact (canine guidance bilaterally).

MUCOSAL TRAUMA / PARAFUNCTION SIGNS

Bilateral linea alba (white lines on buccal mucosa at occlusal level) — consistent with chronic cheek biting / clenching. Mild scalloping of the lateral tongue margins bilaterally (consistent with tongue thrusting against teeth during sleep).

NIGHT GUARD / SPLINT FIT

Patient brought her occlusal guard. Upper soft Drufomat guard: fits adequately on maxillary arch but patient demonstrates gagging during trial seating in the office. Confirms reason for poor adherence. Guard shows significant wear marks on the occlusal surface — confirms she does wear it for at least some portion of the night despite her perception that she removes it entirely.

PERIODONTAL STATUS

Fair — mild generalized gingivitis. No significant periodontal pocketing on gross assessment.

ORAL LESIONS / PAIN SOURCES

No oral lesions. No periapical tenderness. No dental pain source identified.

TM TMJ FUNCTIONAL MEASUREMENTS

6 OBJECTIVE JAW FUNCTION

MAXIMUM INTERINCISAL OPENING

28 mm — RESTRICTED (normal adult female: 40–50 mm; restriction defined as <35 mm). This confirms clinically significant limitation.

ASSISTED OPENING

32 mm with gentle passive force — 4 mm of additional range with passive assist. This is within the range expected for disc displacement without reduction (some passive assist is possible as the condyle moves around the displaced disc; full range is not achievable).

PAIN-FREE OPENING

18 mm — pain onset at 18 mm (RIGHT preauricular; 4/10 at this point). Less than half of normal pain-free opening.

RIGHT LATERAL EXCURSION

7 mm (mildly reduced; normal approximately 8–12 mm). Right lateral excursion involves left condyle translation — relatively preserved.

LEFT LATERAL EXCURSION

4 mm (REDUCED; normal approximately 8–12 mm). Left lateral excursion requires RIGHT condyle translation, which is restricted by the displaced disc — confirms right-sided restriction.

PROTRUSION

6 mm (mildly reduced; normal approximately 6–10 mm). Mild restriction.

DEVIATION OR DEFLECTION

Deviation to the RIGHT on opening (toward affected side) — CONFIRMED on examination. Consistent with right non-reducing disc displacement.

END FEEL

HARD END FEEL at 28 mm on maximum opening — consistent with a mechanical restriction (disc displacement without reduction). A hard end feel (as opposed to a soft or springy end feel) suggests a structural blockage, not simply muscle spasm alone. This is an important clinical differentiator.

JOINT SOUNDS

RIGHT: CREPITUS audible with stethoscope during

PAIN WITH LOADING / RESISTED MOVEMENT

RIGHT TMJ: Positive loading test — pain 5/10 with

opening and closing. No click. LEFT: No sounds.

posterosuperior joint loading via bite on wooden spatula placed between right posterior teeth. This is positive for arthralgia/intra-articular pathology.

FUNCTIONAL LIMITATION

Cannot eat hard foods (steak, raw carrots, apples, bagels), cannot yawn comfortably, difficulty with dental appointments requiring wide opening.

DC PAIN / DISORDER CLASSIFICATION

7 SUSPECTED TMJ DISORDER TYPE

- **Primary disorder:** Disc displacement without reduction with limited opening (right TMJ). Clinical findings supporting this classification:
  1. Previously reported clicking (disc was previously reducing on opening — Wilkes Stage III–IV).
  2. Click is now absent with new onset of limited opening x6 weeks — transition from disc displacement with reduction (click = disc recapture) to without reduction (no click = disc no longer recaptures, blocking opening) is the classic clinical evolution.
  3. Maximum opening 28 mm (restricted).
  4. Hard end feel at maximum opening.
  5. Right jaw deviation on opening (toward the restricted side).
  6. Positive joint loading test (right arthralgia).
  7. Crepitus on opening and closing (degenerative joint changes overlaying the disc displacement — Wilkes Stage IV–V).
- **Secondary disorder:** Myofascial pain with referral — right masseter, temporalis, and pterygoids. This is a dual diagnosis (intra-articular + myofascial), common in chronic TMD, driven by nocturnal bruxism (primary), daytime clenching (stress-driven), anxiety and poor sleep (GAD), and forward head posture.
- **Contributing factors:** GAD (anxiety-driven bruxism); peri-menopausal hormonal changes (estrogen decline and TMJ joint vulnerability); forward head posture; chronic sleep disruption; poor night guard adherence.

L DIAGNOSTIC RESULTS

8 REVIEWED & ORDERED DATA

DENTAL IMAGING

Panoramic radiograph from Dr. Walsh (04/2026) reviewed: bilateral condyles visible; RIGHT condyle shows mild flattening of the condylar head surface and slight subchondral sclerosis — early degenerative changes consistent with osteoarthritis. LEFT condyle: normal morphology. No osseous pathology beyond mild right condylar degenerative changes.

TMJ MRI — ORDERED TODAY

TMJ MRI with open and closed-mouth sequences ordered today (bilateral TMJs, dedicated TMJ protocol). Purpose: (1) confirm disc position (displaced without reduction); (2) characterize disc morphology (deformed, perforated, or intact); (3) assess condylar bone marrow and articular surface; (4) evaluate joint effusion. Order placed through Memorial Regional MRI scheduling — standard priority, within 2–3 weeks.

LABORATORY STUDIES

NOT ordered at this time — clinical presentation is consistent with mechanical TMD and myofascial pain;

PRIOR RECORDS REVIEWED

Dr. Walsh referral note (05/01/2026): 18-month history documented, occlusal guard dispensed and trial

no systemic disease features to prompt labs. If MRI reveals unexpected findings or if symptoms progress without expected response to conservative treatment, inflammatory markers and rheumatologic workup would be considered.

documented, wear facets confirmed, 2 clinical photos attached. ENT note (2025): normal ear examination, referred otalgia from TMD vs primary otologic cause — concluded TMD-related referred pain. Cervical spine MRI report (2024): mild C5-6 spondylosis, no cord compression — reviewed to exclude cervical source of head and neck pain.

A ASSESSMENT

9 TMJ CLINICAL INTERPRETATION

- **Primary diagnosis:** Disc displacement without reduction with limited opening (right TMJ) — probable Wilkes Stage IV–V based on prior clicking → now locking x6 weeks; hard end feel at 28 mm; crepitus; right condylar degenerative changes on panoramic; positive loading test.
- **Secondary diagnosis:** Myofascial pain (bilateral masticatory and cervical muscles, right dominant) — driven by nocturnal bruxism (severe, confirmed), daytime clenching (stress-triggered), and anxiety (GAD).
- **Functional impairment:** Significant — limited opening (28 mm), inability to eat hard foods, sleep disruption from pain, 6-week history of morning locking, and impact on quality of life (husband sleeping separately, anxiety about her jaw).
- **Contributing factors:**
  1. Severe nocturnal bruxism — the primary mechanical driver of both the myofascial pain and the progressive disc displacement.
  2. Poorly controlled anxiety (GAD on sertraline 100 mg, partial response) — drives bruxism and clenching.
  3. Peri-menopausal hormonal changes — estrogen decline is associated with TMJ articular vulnerability and reduced joint lubrication.
  4. Forward head posture — contributes to cervical and masticatory muscle tension.
  5. Poor night guard adherence — the soft guard is worn but removed during the night; soft material may stimulate more clenching in some patients (a hard stabilization splint may be more appropriate).
- **Differential diagnoses excluded:** Infectious arthritis (no fever, erythema, or swelling); coronoid hyperplasia (exam and panoramic argue against); malignancy (no systemic red flags, no palpable mass, no rapid unexplained trismus). Inflammatory arthropathy (RA, psoriatic arthritis): low probability given no systemic features — rheumatology consult if MRI shows significant synovial inflammation or effusion not explained by mechanical pathology.
- **Prognosis:** Moderate with aggressive conservative management. Right disc displacement without reduction with established crepitus and degenerative changes typically does not fully resolve but can achieve excellent functional pain control with conservative care and a well-fitted hard stabilization splint.

P PLAN

10 TMJ MANAGEMENT

1. **Imaging:** TMJ MRI bilateral, dedicated protocol — ordered today, target within 2–3 weeks; results reviewed at follow-up. If MRI confirms disc displacement without reduction with significant degenerative change, will consider TMJ arthrocentesis (minimally invasive lavage) if conservative management does not achieve

adequate improvement within 6–8 weeks.

2. **Conservative management (begin immediately):**
   - **Soft diet** — strict soft diet (no hard foods, gum, bagels, raw carrots, or steak); cut all food into small pieces.
   - **Jaw rest** — avoid wide opening; suppress yawning (jaw-supported yawn technique: fist under chin); no dental work requiring wide opening until re-evaluated.
   - **Heat therapy** — moist heat pack to the right jaw and masseter x15–20 minutes BID (continue and optimize).
   - **Posture correction** — forward head posture correction, ergonomic workstation assessment, chin-tuck exercise 3x daily.
   - **Sleep optimization** — structured sleep hygiene (consistent bedtime, no screens 30 minutes prior, stress reduction before bed; coordinate with Dr. Kim and psychiatry re: sertraline optimization).
3. **Occlusal appliance:** Transition from soft occlusal guard to a custom hard acrylic stabilization splint (Michigan-type maxillary). Impressions and bite registration taken today; fabrication typically 2–3 weeks. Rationale:
   - Hard splints provide better resistance to bruxism forces and may reduce clenching better than soft splints.
   - Hard splints do not stimulate clenching the way soft splints can in some patients.
   - A properly adjusted stabilization splint reduces condylar loading and may decompress the right TMJ joint space.

   Occlusal splint delivery scheduled 05/28/2026.
4. **Home exercise program:**
   - Controlled opening exercises — gentle jaw stretching 3x/day: index fingers on upper and lower incisors, gentle traction to full comfortable opening x10 reps.
   - Jaw posture training — 'lips together, teeth apart, tongue on roof' 5x/day.
   - Relaxation jaw exercise at bedtime.

   Written home program handout provided.
5. **Medications:**
   - Ibuprofen 400 mg TID with food x2 weeks (scheduled dosing reduces the pain cycle).
   - Cyclobenzaprine 5 mg at bedtime x2 weeks — to reduce nocturnal bruxism muscle activity and improve sleep. Counseled on sedation; do not drive 8 hours after taking.
   - Topical diclofenac sodium 1% gel (Voltaren) — apply to the right masseter and preauricular area BID for myofascial pain. Not systemic.
6. **Physical therapy:** Referral placed today for orofacial PT (manual therapy, ultrasound, dry needling if appropriate) — 6–8 sessions, focused on masticatory and cervical muscle release, TMJ mobilization for disc displacement, and posture correction.
7. **Anxiety and bruxism management:** Written note to Dr. Kim requesting:
   - Review of sertraline 100 mg for GAD (partial response — may warrant increase or augmentation).
   - Consideration of a low-dose muscle relaxant or gabapentin for nocturnal bruxism if the cyclobenzaprine short course is insufficient.

   Also provided two stress-reduction resources: an evidence-based mindfulness app (Headspace, 10-minute evening session) and information on biofeedback-assisted relaxation for bruxism.
8. **Patient education:** Explained the TMD mechanism in lay terms, why the disc displacement occurred and progressed, and that the 'missing click' with new locking signals the disc has moved further — the reason for acting more aggressively now. Success requires active participation: night guard wear, soft diet, jaw exercises, and stress management. Patient stated: 'I didn't realize how much my anxiety was connected to my jaw. This explains a lot.'

Follow-up plan:

- 05/28/2026 — stabilization splint delivery and adjustment.
- 06/17/2026 — 6-week follow-up: re-measure jaw opening, re-assess pain (VAS), review MRI results, evaluate PT progress, reassess need for arthrocentesis.
- Arthrocentesis consideration at 06/17/2026 if opening <32 mm despite conservative management.

F FOLLOW-UP

11 REASSESSMENT PLAN

- **Splint delivery:** 05/28/2026 (Dr. Park).
- **6-week comprehensive reassessment (06/17/2026):** jaw opening remeasurement, VAS pain, MRI result review, PT progress, splint wear adherence, medication response, anxiety management update, and need-for-arthrocentesis decision.
- **If arthrocentesis indicated:** procedure scheduling at the 06/17/2026 appointment, or sooner if opening worsens acutely.
- **Urgent return precaution:** if opening worsens significantly before 06/17 (e.g., <20 mm or new severe pain), the patient is instructed to call for an urgent appointment.
- **Long-term:** annual review for ongoing TMD management thereafter if stabilized.

TIME DOCUMENTATION & BILLING

TOTAL TIME
60 minutes

CPT / E/M CODE(S)
99204 — New patient E/M, moderate-high complexity; D9940 — Occlusal guard, by report (impressions for hard stabilization splint)

COUNSELING / COORDINATION TIME
15 minutes (PT referral, occlusal impressions, Dr. Kim coordination, Dr. Walsh coordination, patient education)

BASIS FOR BILLING
Medical Decision Making — Moderate-High Complexity; imaging ordered; multi-modal management plan

PRIMARY ICD-10 CODE
M26.62 — Arthralgia of temporomandibular joint

SECONDARY ICD-10 CODE(S)
M79.1 — Myofascial pain syndrome (masticatory muscles); F41.1 — Generalized anxiety disorder; G47.63 — Sleep related bruxism

PROVIDER SIGN-OFF

PHYSICIAN NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Nathaniel Park, DDS, MD	DDS, MD, Diplomate ABOM	Oral Medicine / Orofacial Pain	05/06/2026	6:15 PM