

Jaw Functional Limitation Scale

For each of the items below, indicate the level of limitation during the past month.

If the activity was completely avoided because it is too difficult, indicate '10.'

If you avoid an activity for reasons other than pain or difficulty, then leave the item blank.

1 Chew tough food	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
2 Chew hard bread	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3 Chew chicken (eg, prepared in oven)	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
4 Chew crackers	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
5 Chew soft food (eg, macaroni, canned or soft fruits, cooked vegetables, fish)	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
6 Eat soft food requiring no chewing (eg, mashed potatoes, apple sauce, pudding, pureed food)	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
7 Open wide enough to bite from a whole apple	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
8 Open wide enough to bite into a sandwich	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
9 Open wide enough to talk	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
10 Open wide enough to drink from a cup	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
11 Swallow	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
12 Yawn	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
13 Talk	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
14 Sing	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
15 Putting on a happy face	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
16 Putting on an angry face	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
17 Frown	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
18 Kiss	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
19 Smile	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
20 Laugh	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation

JFLS-20. Items 1-6 represent mastication, items 7-10 represent mobility, items 11-20 represent verbal and emotional communication.

Patient: _____

Date: ____ / ____ / ____
mm dd yy

Treatment Session #: _____

Pain Diagram and Rating

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Be VERY precise when drawing the location of your pain.

