TMJ QUESTIONNAIRE

Form 401E

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible Please sign each page.

PATIENT INFORMATION

TODAY'S DATE: _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL _____

RESPONSIBLE PARTY _____

PHYSICIAN NAME & ADDRESS _____

_____ REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		1-4	0-10
____	Back Pain	____	____
____	Dizziness	____	____
____	Ear Congestion	____	____
____	Ear Pain	____	____
____	Eye Pain	____	____
____	Facial Pain	____	____
____	Fatigue	____	____
____	Headaches	____	____
____	Jaw Clicking	____	____
____	Jaw Joint Noises	____	____
____	Jaw Locking	____	____
____	Jaw Pain	____	____
____	Limited Mouth Opening	____	____
____	Muscle Soreness	____	____
____	Muscle Twitching	____	____
____	Neck Pain	____	____
____	Pain when Chewing	____	____
____	Ringing in the Ears	____	____
____	Shoulder Pain	____	____
____	Sinus Congestion	____	____
____	Throat Pain	____	____
____	Visual Disturbances	____	____
Other - write in:	____ _____	____	____

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:
_____
_____
_____
_____

Patient Signature _____ Date _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other current medications: _____

MEDICAL HISTORY

Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐High ☐Low
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Current pregnancy
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ *Dizziness*
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent snoring
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart murmur
Y☐ N☐ Heart disorder
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to ☐Face ☐Neck ☐Teeth ☐Head ☐Mouth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Meniere's disease
Y☐ N☐ Migraines
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ *Rheumatoid arthritis*
Y☐ N☐ Scarlet fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Sleep Apnea
Y☐ N☐ Speech difficulties
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Teeth clenching or grinding
Y☐ N☐ Wisdom teeth extraction

Other medical history:
_____
_____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY: MILD	SEVERITY: MODERATE	SEVERITY: SEVERE	FREQUENCY: OCCASIONAL (MONTHLY OR LESS)	FREQUENCY: FREQUENT (WEEKLY)	FREQUENCY: CONSTANT (EVERY DAY)	DURATION: SECONDS	DURATION: MINUTES	DURATION: HOURS	DURATION: DAYS	DURATION: WEEKS
L R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y☐ N☐ Motor vehicle accident
Y☐ N☐ *Motorcycle accident*
Y☐ N☐ Work related incident
Y☐ N☐ Playground incident
Y☐ N☐ Athletic endeavor
Y☐ N☐ Fight
Y☐ N☐ Fall
Y☐ N☐ Accident
Y☐ N☐ Illness
Y☐ N☐ Injury
Y☐ N☐ Unknown

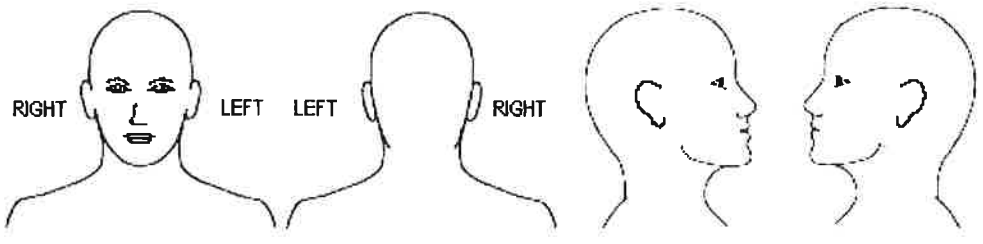
If accident, what was the date? _____

What other information is important to your pain or condition? _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||
MODERATE PAIN ^^^^
SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating



I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____

Dr. Jeffrey Bassman
Center for Headaches, Sleep & TMJ Disorders

Welcome to the Center for Headaches, Sleep & TMJ Disorders. Our goal is to help you improve your overall health and quality of life.

OFFICE POLICIES

Payments: At the time of service, payment is expected in full. As a courtesy, your medical and/or dental insurance will be submitted by our office, once only, per visit, to your primary insurance company. As the subscriber, it is the patients' responsibility to follow up on each claim. Our office is not in the insurance business. We do NOT submit to insurances through the state or Medicare.

We accept cash, checks, Mastercard and VISA as payment and we do participate in the CareCredit program.

Cancellations: We require 24 hour notice if you are unable to keep your appointment. We try to give reminder calls for upcoming appointments, however, we are not always able to reach our patients. Therefore, you are ultimately responsible for remembering your appointments with our office.

We understand that emergencies do arise, but please let us know as soon as you are aware that you are unable to keep your scheduled appointment time.

Signature_____Date_____

Notice of Privacy Practices
Dr. Jeffrey Bassman
Center for Headaches, Sleep & TMJ Disorders
141 East 46th Street, Davenport, IA 52806
(563)391-1525

I understand, that under the Health Insurance Portability and Accountability Act of 1669 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested instructions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____ Date:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below.

Date:_____ Initials:_____ Reason:_____

_____