PLEASE BRING THIS QUESTIONNAIRE WITH YOU FOR YOUR INITIAL VISIT

LARRY Z. LOCKERMAN, D.D.S.
Your appointment has been made at one of these locations.

Locations:
*Headache Center, 85 Prescott St. Worcester, MA 01605
*25 Boylston St, Suite L15, Chestnut Hill MA
1175 Main St East Hartford CT 06108

www.TMJDENTIST.com

PHONE (800)259-0952 FAX (860)528-4477

INSTRUCTIONS:
This questionnaire will help us understand your unique situation and should be completed *before* your first appointment. We know that this form is long and will take time but please read and answer every question carefully and sign the last pages pertaining to you. Please answer these questions by yourself.

Name: _____ Date: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: (____)_____ Work phone: (____)_____

Cell Phone (_____)_____ E Mail:_____

Occupation: _____Firm name and address: _____

_____
Sex:()Male()Female. Birthdate: _____ Age:____ Height:_____ Weight:_____

Social Security Number:_____

Driver license State:_____ # _____

Weight: _____lbs. Race: ()White, ()Black, ()Hispanic, ()Asian, ()Other_____

Marital Status: ()Single, ()Married, ()Divorced,
()Remarried, ()Separated, ()Widowed
Number of children: _____ Age of children: _____

Spouse's name: _____ Occupation: _____

PLACE OF EMPLOYMENT_____

Who referred you to us? _____Relationship?_____
()Doctor: _____ Phone: (_____)_____

Address: _____City_____

Insurance Medical : _____ Subscriber name:_____
Insurance ID#_____ Date of Birth:
Address for mailing Claims: Place Of
Employment:_____

City, State:_____

Who is responsible for this account? ()Self, ()Other: _____

WHAT IS YOUR CURRENT EMPLOYMENT STATUS?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Retired
- ☐ Homemaker
- ☐ Disabled
- ☐ Unemployed

IS THERE ANY LEGAL ACTION PENDING AS A RESULT OF THIS PROBLEM?-☐YES-☐NO

If yes please fill out the last page in this questionnaire.

CHIEF COMPLAINTS LIST IN ORDER OF SEVERITY:

1._____

2._____

3._____

4._____

Symptoms: Do you now or have you ever experienced any of the following symptoms:

	Present Time	In the Past	Never
Frequent Headaches	____	____	____
Facial Pain	____	____	____
Pain or discomfort with chewing	____	____	____
Pain or soreness in jaw joints	____	____	____
Noise in jaw joints	____	____	____
Can't open mouth wide	____	____	____
Locking of jaw when open (can't close)	____	____	____
Locking of jaw when closed (Can't open)	____	____	____
Feeling that bite is off	____	____	____
Clenching and grinding of teeth	____	____	____
Neck and shoulder pain	____	____	____
Tension and stiffness in neck	____	____	____
Difficulty in turning head	____	____	____
Ear pain	____	____	____
Ringing, buzzing, hissing in ears	____	____	____
Hearing loss or fullness in ears	____	____	____
Dizziness (postural imbalance)	____	____	____
Pain in, around and behind eyes	____	____	____
Blurred vision (not corrected by glasses)	____	____	____
Difficulty in swallowing	____	____	____
Painful or burning tongue	____	____	____
Teeth or gum pain	____	____	____
Back pain or aches	____	____	____

History

When did you first notice the symptoms that you listed on the last page?_____

What do you think cause the onset of this condition?

____Auto Accident	____Following illness
____Accident at home	____Stressful situation
____Accident at work	____Pain "just began"
____Medical treatment	____Dental Treatment
____Following surgery	____Other:_____

_____

How fast did the condition arise? _____Over months ____Over weeks
____Over days ____In one day.

How has the condition changed since it began?
____Increased ____Decreased ____Stayed the same

Since your condition began, which of the following people have you consulted for treatment? Indicate year and amount of relief:

	Year	Major Relief	Some Relief	No Change	Felt Worse	Name of doctor or health care provider
Acupuncturist	_____	____	____	____	____	_____
Allergist	_____	____	____	____	____	_____
Chiropractor	_____	____	____	____	____	_____
Dentist	_____	____	____	____	____	_____
Ear, Nose & Throat .	_____	____	____	____	____	_____
Endocrinologist	_____	____	____	____	____	_____
General Practitioner	_____	____	____	____	____	_____
Gynecologist /OB ...	_____	____	____	____	____	_____
Internist	_____	____	____	____	____	_____
Neurologist	_____	____	____	____	____	_____
Nutritionist	_____	____	____	____	____	_____
Ophthalmologist	_____	____	____	____	____	_____
Oral Surgeon	_____	____	____	____	____	_____
Orthodontist	_____	____	____	____	____	_____
Osteopath	_____	____	____	____	____	_____
Physical therapist .	_____	____	____	____	____	_____
Psychologist	_____	____	____	____	____	_____
Psychiatrist	_____	____	____	____	____	_____
Surgeon (general) ..	_____	____	____	____	____	_____
Other- ..	_____	____	____	____	____	_____

Please list any additional specialists and years seen:_____

_____

_____

WHAT MAKES YOUR SYMPTOMS WORSE?

A. _____

B. _____

C. _____

D. _____

WHAT KIND OF THINGS MAKE YOUR SYMPTOMS BETTER?

A. _____

B. _____

C. _____

D. _____

HOW OFTEN DO YOUR SYMPTOMS OCCUR?

___ CONTINUOUSLY
___ ONCE A DAY
___ SEVERAL TIMES A MONTH
___ LESS FREQUENT THAN ONCE A MONTH
____ SEVERAL TIMES A DAY
____ SEVERAL TIMES A WEEK
____ DURING SLEEP

WHEN YOUR SYMPTOMS OCCUR, HOW LONG DO THEY LAST?

___ CONTINUOUSLY
___ FOR DAYS
___ FOR HOURS
___ FOR SECONDS
____ FOR WEEKS
____ FOR HOURS
____ FOR MINUTES
_____ VARIABLE:_____

WHEN ARE YOUR SYMPTOMS WORSE?

___ UPON ARISING
___ AFTERNOON
___ AWAKENS YOU FROM SLEEP
____ MORNING
____ EVENINGS

HAS ANYONE IN YOUR FAMILY A SIMILAR CONDITION? ___YES ___NO

RELATIONSHIP:_____

NAME OF YOUR PRIMARY CARE PHYSICIAN
(If you do not have a primary care the doctor most familiar with you condition):

Name and address:_____

_____

_____Phone # (_____)_____

NAME AND ADDRESS OF YOUR GENERAL DENTIST

NAME AND ADDRESS: _____

_____

_____Phone # (_____)_____

OTHER **DENTISTS** THAT YOU HAVE SEEN FOR THIS CONDITION:
NAME, ADDRESS, and SPECIALTIY_____

_____

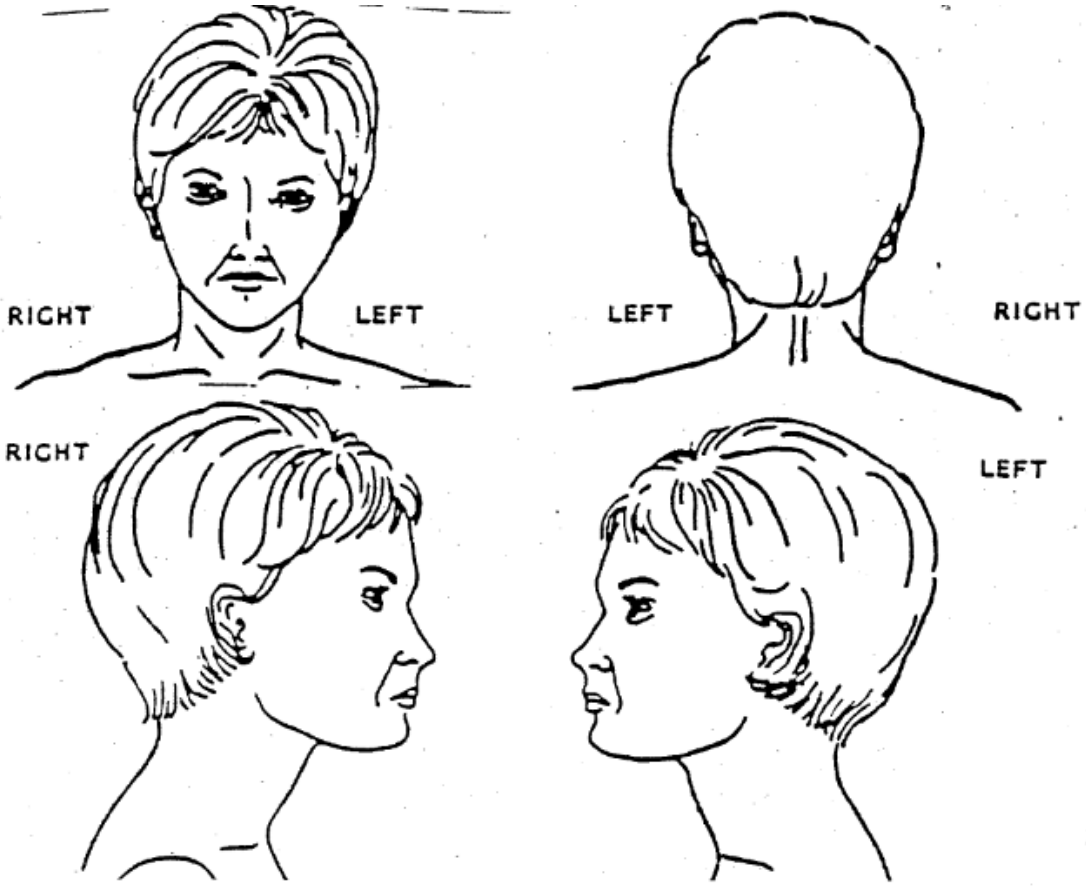
_____

_____

_____

1. Mark the areas where you have pain by shading in the areas with pencil.

2. Mark the exact spot(s) where the pain begins with a solid dot.
3. Indicate any areas of numbness (loss if feeling) with the following ////.
4. Draw a line from where the pains begins and to the area it will spread.



IN THE FOLLOWING QUESTIONS PLEASE CIRCLE YES OR NO,

Constitional Systems			**Ear/Nose and Throat**			**Neurological**		
Fever	Y	N	Hearing loss	Y	N	Stroke	Y	N
Chills	Y	N	Stuffy/ Runny Nose	Y	N	Seizure	Y	N
Headache	Y	N	Sinus infection	Y	N	Head Injury	Y	N
Weight change	Y	N	Allergy/ Hay Fever	Y	N	Memory loss	Y	N
Respiratory			**Gastrointestinal**			**Psychiatric**		
Chronic Cough	Y	N	Abdominal Pain	Y	N	Depression	Y	N
Shortness of Breath	Y	N	Nausea/ vomiting	Y	N	Anxiety	Y	N
Wheezing	Y	N	Heartburn	Y	N	Panic attacks	Y	N
Cardiovascular			**Endocrine**			**Genitourinary**		
Chest Pain	Y	N	Diabetes	Y	N	Increase night urination	Y	N
Palpitations	Y	N	Thyroid problem	Y	N			
Fainting Spells	Y	N	Hormone treatment	Y	N	Hot flashes	Y	N
Eyes								
Glaucoma	Y	N						
Dry Eyes	Y	N						

Do you have any blood disorders such as anemia?----------yes--no
Have you had any surgery, X-rays or drug treatment for your head and neck area?--yes—no
Are you taking any drug or medicine?----------yes—no

6. Have you had any serious illness or operations? ----------yes---no
7. If so what was the problem?_____
8. Do you have any of the following problems or diseases?
   a. Damaged heart valves or artificial heart valves including heart murmur-yes--no
   b. congenital heart problems ----------yes--no
   c. cardiovascular disease (heart trouble, attack, artery blockage, high blood pressure, arteriosclerosis, stroke ----------yes--no

The Epworth Sleepiness Scale

HOW LIKELY IS IT THAT YOU WOULD DOZE OR FALL ASLEEP DURING THE FOLLOWING ACTIVITIES
(PLEASE CIRCLE THE APPROPRIATE NUMBER)

A. SITTING AND READING

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

B. WATCHING TV?

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

C. SITTING INACTIVE IN A PUBLIC PLACE SUCH AS A THEATER OR AT A MEETING?

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

D. AS A PASSANGER IN A CAR FOR AN HOUR?

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

E. LYING DOWN TO REST IN THE AFTERNOON?

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

F. SITTING AND TALKING TO SOMEONE?

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

G. SITTING QUIETLY AFTER LUNCH (WITHOUT ALCHOL)?

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

H. IN A CAR WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC?

0. NO CHANCE
1. SLIGHT CHANCE
2. MODERATE CHANCE
3. HIGH CHANCE

WHICH GROUP OF WORDS BESTS DESCRIBES THE PATTERN OF YOUR PAIN?

____ CONTINUOUS, STEADY, CONSTANT
____ RHYTHMIC, PERIODIC, INTERMITTENT
____ BRIEF, MOMENTARY, TRANSIENT

PLACE A SLASH ALONG THE LINE TO INDICATE THE ANSWER:

EXAMPLE: _____/_____
NO PAIN / MOST PAIN IMAGINABLE

How intense is your *CURRENT* level of pain? _____
NO PAIN MOST PAIN IMAGINABLE

How intense is your *USUAL* level of pain? _____
NO PAIN MOST PAIN IMAGINABLE

How intense is your *HIGHEST* level of pain? _____
NO PAIN MOST PAIN IMAGINABLE

How intense is your *LOWEST* level of pain? _____
NO PAIN MOST PAIN IMAGINABLE

MEDICAL HISTORY:

1. Are you in good health? ____YES ____NO

2. When was your last routine physical?_____

3. Are you being treated for anything other than your current condition?

If yes,explain:_____

_____
Please list any operation and hospitalizations you have had and dates they occurred:

A. _____

B._____

C._____

D._____
Please List any trauma or accidents you have had and the dates they occurred:

A. _____

B. _____

C. _____

IN THE FOLLOWING QUESTIONS PLEASE **CIRCLE YES OR NO**, WHICH EVER APPLIES.

6. Have you had any serious illness or operations?----------yes---no

7. If so what was the problem?_____

8. Do you have any of the following problems or diseases?

a. Damaged heart valves or artificial heart valves including heart murmur-yes--no
b. congenital heart problems----------yes--no
c. cardiovascular disease (heart trouble, attack, artery blockage, high blood pressure, arteriosclerosis, stroke?----------yes--no
1. Do you have chest pain with exertion?----------yes---no
2. Are you ever short of breath after mild exertion?----------yes--no
3. Do your ankles swell?----------yes--no
4. Do you get short of breath when you lie down?----------yes--no
5. Do you require an extra pillow to sleep?----------yes--no
6. Do you have a cardiac pacemaker?----------yes--no
d.Allergies?----------yes--no
1. Sinus trouble----------yes--no
2. Asthma or hay fever?----------yes--no
3. Hives or skin rash?----------yes--no
e. Fainting spells or seizures?----------yes--no
f. Diabetes?----------yes--no
1. Do you have to urinate (pass water)more that 6 times a day?--------yes--no
2. Are you thirsty much of the time?----------yes--no
3. Does your mouth frequently become dry?----------yes--no
g. Hepatitis, jaundice or liver disease?-- ----------yes--no
h. Arthritis?----------yes--no
i. Inflammatory rheumatism (painful swollen joints)?----------yes--no
j. Stomach ulcers?----------yes--no
k. Kidney trouble?----------yes--no
l. Tuberculosis?----------yes--no
j. Do you have persistent cough or cough up blood?----------yes--no
k. Low blood pressure?----------yes--no
l. venereal disease?----------yes--no
m. Herpes virus (periodic sores)?----------yes--no
n. Epilepsy?----------yes--no
o. Cancer?----------yes--no
p. AIDS or other immunosuppressive disorders?----------yes--no

q. Other_____

9. Have you had any abnormal bleeding with previous extractions, surgery or trauma?---yes--no
a. Do you bruise easily?----------yes--no
b. have you had blood transfusions?----------yes--no
If so please explain reason_____

_____

10. Do you have any blood disorders such as anemia?----------yes--no
11. Have you had any surgery, X-rays or drug treatment for your head and neck area?--yes--no
12. Are you taking any drug or medicine?----------yes--no

PLEASE LIST ANY MEDICATION YOU ARE TAKING:

	NAME	DOSE	# TAKEN
1.			
2.			
3.			
4.			

PLEASE LIST ANY OTHER DRUGS YOU HAVE USED IN THE PAST FIVE YEARS FOR YOUR SYMPTOMS:

1. _____ 3. _____

2. _____ 4. _____

13. Please name any other medications not listed on the last page: (please list name and dose)

a. Antibiotics or sulfa drugs:_____g. Aspirin:_____

b. Anticoagulants (blood thinners)_____h.Insulin, tolbutamide or similar_____

c. High blood pressure medicine_____i. Cortisone (steroids)_____

d. Digitalis or heart trouble meds_____j. Nitroglycerine_____

e. Tranquilizers:_____k. Oral Contrceptives_____

f. Antihistamines:_____l. Other_____

14. Are you **allergic** or have you reacted adversely to:

a. Local anesthetics (Novocain or others)--yes--no e. Penicillin or other antibiotics-yes--no
b. Sulfa drugs----------yes--no f. Barbiturates or sedatives-------yes--no
c. Sleeping pills----------yes--no g. Aspirin, or Motrin----------yes--no
d. iodine----------yes--no h. Codeine or other narcotics------yes--no
Others not listed_____
15. Have you had any serious trouble associated with any dental treatments?_____

_____

_____
18 Are you wearing any removable dental appliances or dentures?----------yes--no

WOMEN

19. Are you pregnant?----------yes--no
20. Are you nursing?----------yes--no

\- - - - - -

***DO YOU HAVE*?**	YES	NO
Swollen, stiff or painful joints	_____	_____
Generalized aches and pains	_____	_____
Multiple tender spots	_____	_____
Numbness In hands, fingers, or scalp	_____	_____
Cold hands or feet	_____	_____
Frequent muscle soreness	_____	_____
Tiredness and constant fatigue	_____	_____
Leg cramps at night or when walking	_____	_____
Nails that break easily	_____	_____
Dry skin	_____	_____
Intolerance to cold weather	_____	_____
Constipation	_____	_____

DO YOU:

	YES	NO
Have a stressful situation at work?	_____	_____
Have a stressful situation at home?	_____	_____
Have a decreased appetite?	_____	_____
Feel low in energy or slowed down?	_____	_____
Consider yourself to be a perfectionist?	_____	_____
Feel little interest in doing things?	_____	_____
Feel lonely even with people?	_____	_____
Feel hopeless about the future?	_____	_____
Have a decreased desire for social activities?	_____	_____
Have a loss of sexual interest or pleasure?	_____	_____
See or have ever seen a Psychiatrist, Psychologist, or social worker?	_____	_____

If yes, please explain: _____

_____

SLEEPING HABITS:

DO YOU:	YES	NO
Have a morning headache?	_____	_____
Sleep well at night?	_____	_____
Have trouble falling asleep?	_____	_____
Take medication/alcohol to fall asleep?	_____	_____
Wake up during the night?	_____	_____
Snore while sleeping?	_____	_____
	YES	NO
Mouth breath while sleeping?	_____	_____
Gasp for air in you sleep?	_____	_____
Clench your teeth at night?	_____	_____
Thrash you legs in your sleep?	_____	_____
Feel exhausted upon arising ?	_____	_____
Wake up too early in the morning?	_____	_____
Have stiff muscles in the morning?	_____	_____
	YES	NO
Feel rested upon arising?	_____	_____
Have difficulty staying awake during the day?	_____	_____
Read or watch TV in bed?	_____	_____
Use two pillows?	_____	_____
Sleep on your stomach?	_____	_____

PLEASE NOTE HOW MUCH YOU "CHIEF COMPLAINT" DISTURBS YOUR SLEEP BY CIRCLING THE NUMBER ON THE DIAGRAM:

0 1 2 3 4 5 6 7 8 9 10

No sleep disturbance — completely prevents normal sleep

LIFESTYLE:

Please answer each question with one mark on the line. What is your *usual* level?

Activity	Lie in bed all day	Rest half the day		Rest few times a day	Active all day
Exercise	None	very little	work around the house	moderate	regular
Social activity	None	Very little	Moderate		Very active
Eating	Do not eat	Poor appetite eat lightly		Mostly snack	Eat well
Caffeine Beverages	None	1-2 daily	3-4 daily	Over 6 daily	Not aware
Take vitamins	None	Occasionally		Daily	Use megadoses
Alcoholic beverages	None	On occasion	1-2 daily	3-4 daily	More than 4 daily
Smoke tobacco	None	on occasion	Less than 1 pack/day	More than 1 pack/day	
Recreational drugs	None	On occasion	once per day	More than once per day	

IF YOU ARE TREATED FOR YOUR PROBLEM, WHAT ARE YOUR EXPECTATIONS REGARDING THE OUTCOME OF TREATMENT:

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

CONSENT FOR TREATMENT & TO RELEASE MEDICAL INFORMATION
& AUTHORIZATION FOR INSURANCE CLAIMS CONSENT FOR TREATMENT

1. I hereby and voluntary consent to such procedures, including diagnostic and treatment, as may be deemed necessary by **Larry Lockerman DDS and his associates.**
2. I acknowledge that no guarantees have been made to me as a result that may be obtained.
3. I understand that I have the right to question, discuss or refuse any or all tests and/or treatment.
4. This form has been explained to me and I understand its contents.

CONSENT TO RELEASE MEDICAL/DENTAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

1. I authorize the release of any medical information necessary to process my insurance claims and necessary information for billing statements.
2. I authorize the release of my name to identify work sent to medical and dental laboratories.
3. I authorize and request payment directly to Dr. Larry Lockerman, of medical/dental benefits otherwise payable to me. They will not exceed Dr. Lockerman's regular charges.
4. I understand that I am financially responsible to Dr. Lockerman for any deductible, co-insurance or non-covered services.
5. I agree this authorization will cover all medical/dental services rendered until such authorization is revoked by me by written notification.
6. I authorize the use of the contents of my records for educational purposes or for research activities provided that my identity is *not* revealed in conducting the study.
7. *I authorize an appointment conformation message being left on my answering machine or at my phone number*
8. I agree that a photocopy of this form may be used in lieu of the original.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our full notice is available at our office.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____Relationship to Patient: _____

COMPLETE THIS SECTION ONLY IF YOU SYMPTOMS ARE ACCIDENT or WORK RELATED

ACCIDENTAL INJURY QUESTIONNAIRE

Name:_____

Injury was the result of: Motor vehicle Accident
Occupational injury/workers comp.
Accidental injury

Date of accident: _____

How did the accident occur? _____

_____

Describe your injuries: _____

_____

When did the symptoms first appear? _____

Have you ever had these symptoms before? _____If yes when? _____

Were you hospitalized as a result of the accident? _____ If yes

Hospital name:_____City/Town:_____

Date Admitted:_____ Date discharged: _____

Were you treated in the Emergency Room? _____ If yes, describe treatment:_____

_____

_____

Have you been disabled (unable to work) because of these injuries?_____. if yes, date disability began: _____. Date returned to work:_____.
List any job activity which you can not perform due to you present conditon:_____

_____
YOUR ATTORNEY'S NAME AND ADDRESS

NAME:_____PHONE (_____)_____

ADDRESS: _____

CITY:_____ZIP: _____
Motor vehicle or worker's compensation insurance information:

Carrier: _____Policy #_____Claim#_____

Claim examiner or contact person:_____