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Pre-Adjustment Questionnaire

Adjustment #:_____

Name: _____ Date: _____

Time since last adjustment: _____

1) Have you been wearing your splint full time? Yes_____ No_____

1a) If not, about what percent of the time are you wearing your splint? ~_____%

1b) Are you eating with your splint? Yes_____ No_____

2) Do you notice any issues with your jaw joints? Yes_____ No_____

2a) If yes please mark all that apply:

Pain: R___ L___ popping/clicking: R___ L___ limited opening: ___ locking: ___

3) Please rate your jaw comfort on a scale of 1-10? (10 being most comfortable)

3a) Joint comfort rating: _____

4) Please rate your facial muscle comfort on a scale of 1-10? (10 being most comfortable)

4a) Muscle comfort rating: _____

5) Have you had any headaches, neck aches, ear aches, sinus pain, or other pain that I should be aware of? _____

6) Have you noticed any other changes? Yes _____ No _____

6a) If yes, please explain: _____

_____

7) When you bite gently with your splint in, where do you feel your teeth touch first?

_____

8) Is your splint overall more or less comfortable since your last adjustment?

_____

FOR OFFICE USE ONLY

First point of contact: _____ ROM: _____

VDO: _____ Stable?_____

Bite Record VDO: _____ Photos Taken? _____