DTR/FDH Scaling Form Patient:______________________ Date:_______

A) Tooth Sensitivity Pain Scale

Office Use:

With EMG *W/O EMG*

preop *postop*

Canine Rise #'s ____________

Rate your tooth sensitivity pain on a scale from 0 to 10:

0 no pain whatsoever
1 I almost never feel it
3 I'm aware of it several times a week
5 pain that just barely needs store bought medication
7 I really should see my dentist
9 I must have stronger medication and need to see my dentist today!
10 THE worst possible pain!

Please describe your tooth sensitivity pain to a ***5 second ice water swish***:

No Pain **Very Painful**

0 1 2 3 4 5 6 7 8 9 10

B) Occlusion/Bite Related Questions

Do you: PLEASE CIRCLE THE NUMBER IF YES :

1- drink cold drinks through a straw to prevent a painful response in your teeth?
2- experience that tooth sensitivity pain dissipates rapidly?
3- have trouble eating crunchy or chewy foods?
4- have trouble drinking a cold drink or eating ice cream?
5- experience pain in your teeth when breathing in cold air that dissipates when you close your mouth and breathe through your nose?
6- experience a transient sensitivity pain in several of your teeth or a general area?
7- feel that your jaw and cheek muscles are often tight?
8- notice that chewing gum or chewy foods makes your jaw tired?
9- clench or grind your teeth?
10- notice that you consciously keep your lower teeth from touching your upper teeth because your teeth hurt slightly if not?
11- find yourself sticking your tongue between your front teeth sometimes?

C) Less Related to Occlusion Questions

Do you: PLEASE CIRCLE THE NUMBER IF YES:

12- feel that your tooth sensitivity pain lingers long after the hot or cold stimulus is gone?
13- experience lingering pain after separating your teeth between crunchy foods?
14- feel that cold makes the pain in your tooth or teeth feel better?
15- experience pain in your tooth or teeth that wakes you up at night?
16- notice that you consciously keep your lower teeth from touching your upper teeth because your teeth hurt unbearably if not?
17- find that you must put something between your front teeth or the pain is unbearable?
18- think that you know exactly the one tooth that's causing your pain?
19- feel that you cannot open your jaw as far as you used to?
20- feel that hot drinks are intolerable and lead to a very painful response?

CONTINUED ON BACK

D) Headache/Tension Related Questions (answer if you experience headaches):

Do you: PLEASE CIRCLE THE NUMBER IF YES:

21- have debilitating headaches that require a trip to your physician?
22- have mild headaches that only require over the counter medication?
23- feel that the headaches are new to you?
24- get LIGHT SENSITIVE when you have headaches?
25- get NAUSEOUS when the headaches happen?
26- find that the headaches are IMPACTING your work, school, or recreational activities?
27- find that the headaches are intense and throbbing?
28- get upper neck tension or pain with your headaches?
29- get shoulder tension or with your headaches?
30- ***feel that you have been >50% disabled from your headaches for more than 11 of the last 90 days?***

E) Past Providers/Therapies

Have you seen a **dentist** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you seen a **Primary Care Doctor** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you seen an **ENT Specialist** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you seen a **Neurologist** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you seen a **Chiropractor** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you tried, **Acupuncture Massage Therapist, or Physical Therapist?**

F) Please take a photo of your teeth with back teeth together, and lips retracted. This is a very important step for patients traveling from long distances

Do you suffer from any of the following?

Circle any symptoms you suffer from

Patient Name: ______________________ Date: ______________

Head Pain, Headache

- Forehead
- Temples
- “Migraine” Type
- Sinus Type
- Shooting Pain Up Back of Head
- Hair and/or Scalp Painful to Touch
- Brain Fog

Eyes

- Pain Behind Eyes
- Bloodshot Eyes
- May Bulge Out
- Sensitive to Sunlight
- Weeping Eyes
- Double Vision
- Problems Tracking While reading
- Eye Muscle Twitching

Mouth

- Discomfort
- Limited Opening of Mouth
- Inability to Open Smoothly
- Jaw Deviates to One Side When Opening
- Locks Shut or Open
- Can’t Find bite

Ear Problems

- Hissing, Buzzing or Ringing
- Decreased Hearing
- Ear Pain, Ear Ache, No Infection
- Clogged, “Itchy” ears
- Vertigo, Dizziness

Jaw Problems

- Clicking, Popping Jaw Joints
- Grating Sounds
- Pain in Cheek Muscles
- Uncontrollable Jaw and/or Tongue Movements

Neck Problems

- Lack of Mobility, Stiffness
- Neck Pain
- Tired, Sore Muscles
- Shoulder Aches and Back Aches
- Arm and Finger Numbness and/or Pain

Teeth

- Clenching, Grinding at Night
- Looseness and Soreness of Back Teeth
- Tooth Sensitivity to Cold or Ice

Throat

- Swallowing Difficulties
- Laryngitis
- Sore Throat With No Infection
- Voice Irregularities or Changes
- Frequent Coughing or Constant Clearing of Throat
- Feeling of Foreign Object in throat Constantly
- Feeling of "hand resting on throat"

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TNT Dental

EPWORTH SLEEPINESS SCALE

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping.
2 = *moderate* chance of dozing or sleeping.
3 = *high* chance of dozing or sleeping.

Fill in your answers and see where you stand.

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle For an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic While driving	
Total score (add the scores up) (This is your Epworth Score)	

Do you snore?	Yes	No
Does your spouse snore?	Yes	No