



GREGORY ABATE DDS

Aesthetic and Preventive Dentistry

Patient Questionnaire for temporomandibular Disorders Treatment Progress

1. How are you feeling today on a scale of 1 to 10?
(1 = No Pain 10 = Worst Possible) Circle your choice.

1 2 3 4 5 6 7 8 9 10

2. How have you felt since your last appointment on a scale of 1 to 10?
(1 = No Pain 10 = Worst Possible) Circle your choice.

1 2 3 4 5 6 7 8 9 10

3. What symptoms (if any) are better?

4. What symptoms (if any) are the same?

5. What symptoms (if any) are worse?

6. Do you feel our therapy is helping you? Please circle. YES NO

7. If you are receiving physical therapy at another facility, do you feel that the therapy is helping you? Please circle. YES NO

8. On average I have worn my appliance(s) _____ hours per day.

Patient Signature

Reviewed By