



PRE-TREATMENT QUESTIONNAIRE

We would be grateful if you could please circle the responses to the following questions. Where 0 is if you have “no problems at all” and 10 is the “worst you have ever experienced” e.g. Headache 0 is no headache and 10 is excruciating/unbearable headache.

1) Are you aware that you clench/grind your teeth? Yes/No

2) Do you suffer from any of the following symptoms?

Please circle the following:

- a) Toothache 0 1 2 3 4 5 6 7 8 9 10
- b) Headache/Migraine 0 1 2 3 4 5 6 7 8 9 10
- c) Earache/Dizziness 0 1 2 3 4 5 6 7 8 9 10
- d) Feeling Stressed/Crisis 0 1 2 3 4 5 6 7 8 9 10
- e) Pain in jaw 0 1 2 3 4 5 6 7 8 9 10
- f) Broken teeth/fillings 0 1 2 3 4 5 6 7 8 9 10
- g) Neck/shoulder pain 0 1 2 3 4 5 6 7 8 9 10
- h) Sensitive teeth 0 1 2 3 4 5 6 7 8 9 10
- i) Sleep Deprivation 0 1 2 3 4 5 6 7 8 9 10

3) Did your dentist or has a member of the dental team show/explain the problem to you? Yes/No

4) Do you have an appliance to wear? Yes/No

If no ignore question 5

5) Do you wear your appliance? Yes/No

Please add comments about your experience of wearing your appliance and as to any positive/negative effects it may have had

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OCCLUSAL SPLINT THERAPY

Grinding & Clenching of Teeth

Many people clench and/or grind their teeth at night whilst asleep and do not even realize it. Grinding and clenching know as bruxism, can unknowingly be the cause of headaches and tension in the neck and shoulders. Common signs of bruxism are worn or chipped teeth.

Screening Diagnosis & Treatment Protocol

Name:	DOB:
Address:	Tel No:
Occupation:	Gender:
Patient No:	