DO YOU:

Clench or grind your teeth while awake or asleep?
Yes___ No___

Bite your lips or cheeks regularly?
Yes___ No___

Hold foreign objects with your teeth?
(Pencils, pipe, pins, nails, fingernails)
Yes___ No___

Have tired jaws especially in the morning?
Yes___ No___

Smoke or chew tobacco? Yes___ No___

Sore Muscles (neck, shoulders) Yes___ No___

ARE YOU SATISFIED WITH YOUR TEETH'S APPERANCE? **Yes** **No**

Would you like to keep all of your teeth all of your life? Yes___ No___

Do you feel nervous about having dental treatment? Yes___ No___

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes____ No____

If yes, please describe _____

_____