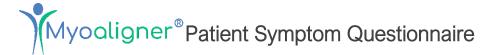


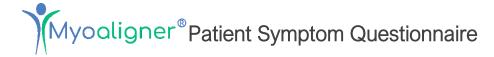
Patient Information			
			M/F
Name		Age	Gender
Provider Information			
		( )	
Provider Name		Phone	
Treatment			
Date of First Appointment (before initiating t	reatment):	/	
Date of Last Appointment (3 months post-del	ivery of the	appliance)://_	
Myoaligner® Appliance (circle one):			
1. Removable <b>Segmented</b> :	2 pc.	3 pc.	
2. Removable Full Arch:	clear	tooth colored	
3. Bondable Segmented:	2 pc.	3 pc.	
Research Participation Consent			
The purpose of this questionnaire is to co anonymous. By signing this form, participhe looked at by responsible individuals we confirms they have had the opportunity to	pant under here it is r	stands that sections of hi elevant to take part in re	is/her medical notes may esearch. Participant
I, agree to take	e part in re	esearch conducted by Myd	oaligner®
Patient Signature			Date



## Before Myoaligner® Treatment

Rate these symptoms from 1 (no pain) – 10 (very painful)

Headaches	1	2	3	4	5	6	7	8	9	10
TMJ Pain	1	2	3	4	5	6	7	8	9	10
TMJ Noise	1	2	3	4	5	6	7	8	9	10
Limited Jaw Opening	1	2	3	4	5	6	7	8	9	10
Ear Pain/Congestion	1	2	3	4	5	6	7	8	9	10
Vertigo (dizziness)	1	2	3	4	5	6	7	8	9	10
Tinnitus (ringing in ear)	1	2	3	4	5	6	7	8	9	10
Dysphagia (difficulty swallowing)	1	2	3	4	5	6	7	8	9	10
Clenching	1	2	3	4	5	6	7	8	9	10
Bruxing (tooth grinding)	1	2	3	4	5	6	7	8	9	10
Pain in Temples	1	2	3	4	5	6	7	8	9	10
Facial Pain	1	2	3	4	5	6	7	8	9	10
Tender/Sensitive Teeth	1	2	3	4	5	6	7	8	9	10
Difficulty Chewing	1	2	3	4	5	6	7	8	9	10
Upper Cervical Pain (neck)	1	2	3	4	5	6	7	8	9	10
Postural Problems	1	2	3	4	5	6	7	8	9	10
Paresthesia of Fingertips (tingling	) 1	2	3	4	5	6	7	8	9	10
Nervousness/Anxiety	1	2	3	4	5	6	7	8	9	10
Insomnia	1	2	3	4	5	6	7	8	9	10
Facial Asymmetry	1	2	3	4	5	6	7	8	9	10
Poor Facial Profile	1	2	3	4	5	6	7	8	9	10
Forward Head Posture	1	2	3	4	5	6	7	8	9	10
Facial Edema (swelling)	1	2	3	4	5	6	7	8	9	10
Chipped/Worn Down Teeth	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10



## After Myoaligner® Treatment

Rate these symptoms from 1 (no pain) – 10 (very painful)

Headaches	1	2	3	4	5	6	7	8	9	10
TMJ Pain	1	2	3	4	5	6	7	8	9	10
TMJ Noise	1	2	3	4	5	6	7	8	9	10
Limited Jaw Opening	1	2	3	4	5	6	7	8	9	10
Ear Pain/Congestion	1	2	3	4	5	6	7	8	9	10
Vertigo (dizziness)	1	2	3	4	5	6	7	8	9	10
Tinnitus (ringing in ear)	1	2	3	4	5	6	7	8	9	10
Dysphagia (difficulty swallowing)	1	2	3	4	5	6	7	8	9	10
Clenching	1	2	3	4	5	6	7	8	9	10
Bruxing (tooth grinding)	1	2	3	4	5	6	7	8	9	10
Pain in Temples	1	2	3	4	5	6	7	8	9	10
Facial Pain	1	2	3	4	5	6	7	8	9	10
Tender/Sensitive Teeth	1	2	3	4	5	6	7	8	9	10
Difficulty Chewing	1	2	3	4	5	6	7	8	9	10
Upper Cervical Pain (neck)	1	2	3	4	5	6	7	8	9	10
Postural Problems	1	2	3	4	5	6	7	8	9	10
Paresthesia of Fingertips (tingling	) 1	2	3	4	5	6	7	8	9	10
Nervousness/Anxiety	1	2	3	4	5	6	7	8	9	10
Insomnia	1	2	3	4	5	6	7	8	9	10
Facial Asymmetry	1	2	3	4	5	6	7	8	9	10
Poor Facial Profile	1	2	3	4	5	6	7	8	9	10
Forward Head Posture	1	2	3	4	5	6	7	8	9	10
Facial Edema (swelling)	1	2	3	4	5	6	7	8	9	10
Chipped/Worn Down Teeth	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10