Myoaligner® Patient Symptom Questionnaire

Patient Information

______________________	________	M / F
Name	Age	Gender

Provider Information

______________________	(____) ______ - _______
Provider Name	Phone

Treatment

Date of First Appointment (before initiating treatment): _____/_____/_____

Date of Last Appointment (3 months post-delivery of the appliance): _____/_____/_____

Myoaligner® Appliance (circle one):

1. Removable **Segmented**: 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 collect data on Myoaligner® appliances. **All data will be anonymous**. By signing this form, participant understands that sections of his/her medical notes may be looked at by responsible individuals where it is relevant to take part in research. Participant confirms they have had the opportunity to ask questions, all of which have been answered fully.

I, ________________________ agree to take part in research conducted by Myoaligner®
Print Name

____

Patient Signature Date

Myoaligner® Patient Symptom Questionnaire

Before Myoaligner® Treatment

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

Symptom										
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

Myoaligner® Patient Symptom Questionnaire

After Myoaligner® Treatment

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

Symptom										
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
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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