Tysons Aesthetic Dentistry

Patient Progress Report Visit#___

NAME: ________________________________ **DATE:**________________

List any symptoms since your last visit that you want to bring to our attention:

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ORTHOTIC WEAR: circle one **NIGHT TIME** **DAY TIME** **DAYTIME & NIGHT**

Indicate your current degree of discomfort or pain by circling the corresponding number.

DEGREE OF DISCOMFORT Chief Complaints:	No Pain	Mild	Moderate	Severe	Worst Possible
TMJ clicking/grating	0	1 2 3 4	5 6	7 8 9	10
TMJ locking/stiffness	0	1 2 3 4	5 6	7 8 9	10
Inability to open mouth	0	1 2 3 4	5 6	7 8 9	10
Mouth doesn't open straight	0	1 2 3 4	5 6	7 8 9	10
Pain when eating/chewing	0	1 2 3 4	5 6	7 8 9	10
Pain in jaw or jaw joint	0	1 2 3 4	5 6	7 8 9	10
Unstable bite	0	1 2 3 4	5 6	7 8 9	10
Headache	0	1 2 3 4	5 6	7 8 9	10
Face pain	0	1 2 3 4	5 6	7 8 9	10
Neck pain	0	1 2 3 4	5 6	7 8 9	10
Ear pain/stuffiness	0	1 2 3 4	5 6	7 8 9	10
Ringing in ears	0	1 2 3 4	5 6	7 8 9	10
Difficulty swallowing	0	1 2 3 4	5 6	7 8 9	10
Throat pain	0	1 2 3 4	5 6	7 8 9	10
Face muscle fatigue	0	1 2 3 4	5 6	7 8 9	10
Other____________	0	1 2 3 4	5 6	7 8 9	10
Other____________	0	1 2 3 4	5 6	7 8 9	10

Any Changes/Improvements in Sleep Patterns?

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Total improvement since beginning of treatment ____________%

PATIENT'S SIGNATURE: ____