PATIENT BASIC MOTIVATION QUESTIONNAIRE

Name: ____________________________________ **Date:** __________________

Patients often request changes in their bite or face and relief from pain or discomfort. Please help us understand your problem by checking the following information. Please be specific (check the words backward, less, shorter, etc.)

Teeth: If your teeth could be changed, how would you like them to change?

□	Straighten the front teeth	□ upper	□ lower
□	Straighten the back teeth	□ upper	□ lower
□	Move upper teeth	□ forward	□ backward
□	Move lower teeth	□ forward	□ backward
□	Make the line of the upper teeth more level		
□	Move the midline of the □ upper/ □ lower teeth to □ left/ □ right		
□	Other ……………….		

Face: If your facial appearance could be changed, what would you change?

□	Move chin	□ forward	□ backward
□	Move chin to center it	□ left	□ right
□	Move lower lip	□ forward	□ backward
□	Move upper lip	□ forward	□ backward
□	Show □ more/ □ less of my □ teeth/ □ gums when I smile		
□	Make my lips □ closer together/ □ farther apart when my teeth are touching		
□	Make my lips not touch and roll out when my teeth are touching		
□	Other ………………		

Symptoms: If you want to reduce pain or discomfort, where would it be located? Please be specific about the location; check the right side, left side, or both if they apply.

□	In front of my ears	□ right	□ left
□	Below my ears	□ right	□ left
□	Above my ears	□ right	□ left
□	In my ears	□ right	□ left
□	Neck	□ right	□ left
□	Shoulders	□ right	□ left
□	Temples	□ right	□ left
□	Eyes	□ right	□ left
□	Teeth		
□	Sinuses		
□	Other…………………		