ANDOLINO
ORTHODONTICS PC

NAME_____DATE_____

TREATMENT MOTIVATION SURVEY

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us understand your problem by checking the following information: please be specific. (Circle the words: more, less, forward, backward, longer, 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
__Make the upper front teeth longer/shorter
__Move upper teeth forward/backward
__Move lower teeth forward/backward
__Make the line of the upper front teeth level forward/backward
__Move the midline of the upper/lower teeth to the right/left
Other_____

FACE

If you're facial appearance could be changed what would you change?

__Get rid of sag under lower jaw
__Move chin forward/backward
__Move chin left/right to center it
__Move lower lip forward/backward
__Move upper lip forward/backward
__Move the area around my nose forward/backward
__Move the area under my eyes forward/backward
__Make my cheekbones larger/smaller
__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
__Reduce the strain in my chin/lips when I close my lips
__Make my face more narrow/wide
__Reduce the width/fullness of my lower jaw behind my mouth
Other_____

SYMPTOMS

If you want to reduce pain or discomfort where would it be located? Please be specific about the location: circle 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
__Temples right/left
__Teeth
__Sinuses
__Eyes right/left
Other _____

41 East 57th Steet, New York, NY 10022 * 212-753-5575 (f) 212-825-5060