Consultation Questionnaire

In order for us to tailor your consultation to fit your needs, please answer the following questions completely and thoroughly using extra paper if needed.
Please remember to bring this to your appointment and we will review it together then.

1) **What do you feel is your main dental problem? What do you feel is wrong? How long have you suffered?**

   _____
   _____
   _____

2) **Do you have (circle) dentures or partials? How long have you had them? Do you wear them every day and all of the time?**

   _____
   _____
   _____

3) **What do you want to hear at your consultation visit with Dr. Adatia?**

   _____
   _____
   _____

4) **When do you want to start your care?** _____
5) **What is the most important thing you want to see in yourself when your dental care with Dr. Adatia is completed?**

   _____
   _____
   _____

Please rank each of the following and how they will influence whether you can get your dental treatment completed:

1 = will not keep me from getting my dental treatment
5 =will very likely keep me from getting my dental treatment

The COST of dental treatment	1	2	3	4	5
My FEAR of the dentist	1	2	3	4	5
My lack of TIME	1	2	3	4	5
My EXPECTATIONS are unrealistic	1	2	3	4	5

I have been involved or am currently involved with a legal claim or lawsuit involving a medical/dental provider:

Circle (YES) (NO)

Patient Signature _____ Date _____

Please check ALL of the following problems you are experiencing:

- ❑ Avoid eating in public
- ❑ Avoid being seen in public
- ❑ Ashamed to smile
- ❑ Anxiety about your smile
- ❑ Teeth are unsightly
- ❑ Social embarrassment
- ❑ Unattractive smile
- ❑ Loss of self esteem
- ❑ Teeth do not look real
- ❑ Denture/partial looks phony/fake
- ❑ Loss of confidence from teeth
- ❑ Withdrawal from social interactions
- ❑ Increased wrinkles
- ❑ Face falling in
- ❑ Feel older than you are
- ❑ Dentures create gagging
- ❑ Inconvenience
- ❑ Loss of support for the face
- ❑ Shrinking bone
- ❑ Shrinking gums
- ❑ Difficulty chewing
- ❑ Change in foods you eat/Difficulty swallowing
- ❑ Nutritional/Digestive Disorders
- ❑ Limitations of foods that can be eaten
- ❑ Avoid foods you would like to have
- ❑ Decreased taste of food

Other (please explain) _____

- ❑ Numbness where denture presses
- ❑ Pain on chewing
- ❑ Chew better without your partials/dentures
- ❑ Teeth are uncomfortable
- ❑ Dentures/Partials are painful
- ❑ Must use denture adhesive (Upper)
- ❑ Must use denture adhesive (Lower)
- ❑ Teeth move so much you don't wear them
- ❑ Unstable dentures/partials
- ❑ Sores under dentures/partials
- ❑ Partials make teeth sore
- ❑ Unnatural feel to denture/partial
- ❑ Difficulty speaking
- ❑ Food trapped between/ under your teeth
- ❑ Difficulty in dealing with stress
- ❑ A need to feel whole again
- ❑ Depressed/ insecure about loss of teeth
- ❑ Burning sensations
- ❑ Headaches
- ❑ Teeth/jaw grinding
- ❑ Dizziness or ringing in the ears
- ❑ Jaw is sore
- ❑ Previous traumatic or bad dental experiences
- ❑ Difficulty in physical relationships due to my teeth
- ❑ Difficulty adjusting to life without my own teeth