

Patient Basic Motivation Questionnaire

Name:..... Date

Patients often request changes in their bite or faces and relief from pain or discomfort. Please help us to understand your problem by checking the following information.

Please be specific, check (✓) the areas where you would like to improve your appearance.

Teeth

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

- | | | |
|-------------------------------------------------------------------------|-------------------------------|--------------------------------|
| <input type="radio"/> Straighten the front teeth | <input type="radio"/> Upper | <input type="radio"/> Lower |
| <input type="radio"/> Straighten the back teeth | <input type="radio"/> Upper | <input type="radio"/> Lower |
| <input type="radio"/> Move Upper Teeth | <input type="radio"/> Forward | <input type="radio"/> Backward |
| <input type="radio"/> Move Lower Teeth | <input type="radio"/> Forward | <input type="radio"/> Backward |
| <input type="radio"/> Move the midline of the upper to the | <input type="radio"/> Left | <input type="radio"/> Right |
| <input type="radio"/> Move the midline of the Lower to the | <input type="radio"/> Left | <input type="radio"/> Right |
| <input type="radio"/> Make the line of the Upper Front Teeth more level | | |

Other

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Face

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

- | | | |
|--------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------|
| <input type="radio"/> Move Chin | <input type="radio"/> Forward | <input type="radio"/> Backward |
| <input type="radio"/> Move Chin to centre it | <input type="radio"/> Left | <input type="radio"/> Right |
| <input type="radio"/> Move Lower Lip | <input type="radio"/> Forward | <input type="radio"/> Backward |
| <input type="radio"/> Move Upper Lip | <input type="radio"/> Forward | <input type="radio"/> Backward |
| <input type="radio"/> Show more of my | <input type="radio"/> Teeth | <input type="radio"/> Gums when I smile |
| <input type="radio"/> Show less of my | <input type="radio"/> Teeth | <input type="radio"/> Gums when I smile |
| <input type="radio"/> Make my lips not touch and roll out when my teeth are touching | | |

Other

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Patient's signature: Date: