Patient Survey — 6 Months After Treatment

Please mark answers with an "X" in the corresponding box. It is very important that the responses be recorded within the space allotted. Example: [X]

When recording numerical responses, such as amounts or dates, one number should be entered into each box. Example: [0][1] / [0][3] / 20[1][0]

Today's Date [ ][ ] [ ][ ] 201[ ]
mm dd y

1. How many days in the past month have you had pain in the area that was treated with a root canal?

   [ ][ ] Days (If no pain, please write "0/0")

2. Have you taken anything for the pain (over-the-counter or prescription medication, herbal, other) in the last 1 month?
   a. ☐ Yes
   b. ☐ No

IF PAIN WAS NOT PRESENT IN THE PAST ONE MONTH, SKIP TO QUESTION #12

Please CIRCLE ONE NUMBER for questions#3 – 5

3. How would you rate your tooth pain on a 0 to 10 scale at the present time, that is right now, where 0 is "no pain" and 10 is "pain as bad as could be"?

No Pain **Pain as bad as could be**

0 1 2 3 4 5 6 7 8 9 10

4. In the past month, how intense was your worst tooth pain rated on a 0 to 10 scale where 0 is "no pain" and 10 is "pain as bad as could be"?

No Pain **Pain as bad as could be**

0 1 2 3 4 5 6 7 8 9 10

5. In the past month, on the average, how intense was your tooth pain rated on a 0 to 10 scale where 0 is "no pain" and 10 is "pain as bad as could be"? (That is, your usual pain at times you were experiencing pain.)

No Pain **Pain as bad as could be**

0 1 2 3 4 5 6 7 8 9 10

SEE PAGE 2

6. About how many days in the past month have you been kept from your usual activities (work, school or housework) because of tooth pain? ☐☐ Days (If none, please write "0/0")

Please CIRCLE ONE NUMBER for questions #7 – 9

7. In the past month, how much has tooth pain interfered with your daily activities rated on a 0 to 10 scale where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference										**Unable to carry on any activities**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

8. In the past month, how much has tooth pain interfered with your ability to take part in recreational, social and family activities where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference										**Unable to carry on any activities**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

9. In the past month, how much has tooth pain interfered with your ability to work (including housework) where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference										**Unable to carry on any activities**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

10. Has your tooth pain been present for at least 8 hours a day, 15 days or more a month, over the last 3 or more months?
    a. ☐ Yes
    b. ☐ No [If no, skip to Question 12.]

11. If yes, what do you think was the cause of this tooth-type pain (please mark **only ONE** response)?
    a. ☐ dental disease / infection (e.g., toothache)
    b. ☐ dental treatment (e.g., root canal therapy)
    c. ☐ trauma (e.g., traffic accident, injury, fall)
    d. ☐ illness (e.g., cold, sinus infection, ear infection)
    e. ☐ other pain(s) (e.g., headaches, TMJ/TMD)
    f. ☐ stress
    g. ☐ don't know

12. Please rate how your feelings of fear about having a root canal compared to the actual experience.
    a. ☐ does not apply – I was not afraid.
    b. ☐ the experience was *better* than I feared.
    c. ☐ the experience was about what I feared.
    d. ☐ the experience was *worse* than what I feared.

SEE PAGE 3

13. In the last 3 months, which of the following treatments have you sought to manage pain associated with your tooth that received root canal therapy? **(Mark all that apply and indicate the number of treatments in the last 3 months.)**

A. **Additional dental treatment(s):**

1. ☐ Additional root canal treatment(s): How many appointments? ☐☐
2. ☐ Extraction of the tooth (tooth was removed)
3. ☐ Additional x-rays: How many appointments? ☐☐

B. **Medication(s) or supplement(s):**

1. ☐ Pain medication (prescription or over the counter)
2. ☐ Antibiotics
3. ☐ Herbal/botanical

C. ☐ **Appointment(s) with a medical doctor**: How many appointments? ☐☐

D. **Alternative, complementary, or non-traditional health therapies:**

1. ☐ Chiropractic care: How many appointments? ☐☐
2. ☐ Acupuncture or acupressure: How many appointments? ☐☐
3. ☐ Other: (please list) _____

E. ☐ **None of the above.**