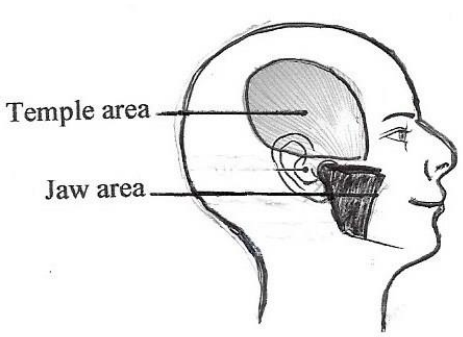
Doctor Follow-up Questionnaire



The following questions pertain to your patient's adherence to your current recommended treatments and to any changes you may have made to their initial diagnoses or treatment recommendations.

1. Has your patient <u>returned</u> for a **follow-up visit** since initial enrollment in the study?

   ☐ Yes ----------→ Go to question 2

   ☐ No ----------→ **Then you are done.**

2. How well has your patient <u>adhered</u> **OVERALL** to your treatment recommendations?

Not adherent	Somewhat adherent	Very adherent
☐	☐	☐

3. Please rate your patient's **adherence** to the following **SPECIFIC** treatment recommendations. Check N/A if not recommended.

Treatments		**Level of adherence**		
	N/A	**Not adherent**	**Somewhat adherent**	**Very adherent**
Wear a mouth guard when **awake**	☐	☐	☐	☐
Wear a mouth guard when **eating**	☐	☐	☐	☐
Wear a mouth guard when **sleeping**	☐	☐	☐	☐
Medication				
Self-care	☐	☐	☐	☐
Jaw exercises	☐	☐	☐	☐
See physical therapist	☐	☐	☐	☐
See chiropractor				
See psychologist, psychiatrist, counselor or social worker	☐	☐	☐	☐
Other (*please specify*):	☐	☐	☐	☐

4. Please indicate any **difficulty** you have experienced in implementing the treatment.

Financial cost to the patient	☐ Yes ☐ No
Lack of insurance coverage	☐ Yes ☐ No
Side effects of the treatment	☐ Yes ☐ No
Patient's compliance	☐ Yes ☐ No
Difficult or time consuming for the patient	☐ Yes ☐ No
Treatment was not the patient's preference	☐ Yes ☐ No
Treatment may not be effective	☐ Yes ☐ No
Treatment may only have a short-term effect	☐ Yes ☐ No
Time consuming for you to implement	☐ Yes ☐ No
Treatment is difficult for you to implement	☐ Yes ☐ No
Minimal experience or training doing treatment	☐ Yes ☐ No
Availability of physical therapist for referral	☐ Yes ☐ No
Availability of psychologist for referral	☐ Yes ☐ No
Other (*please specify*):	☐ Yes ☐ No

The following questions ask **your opinion** about the impact of your treatment on your patient's pain.

5. How much did the treatment **relieve** your patient's pain?

No relief										**Complete relief**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. How much did the treatment **improve** your patient's ability to use their jaw?

No improvement										**Complete improvement**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. How **satisfied** was your patient with the treatment?

Not at all satisfied										**Very satisfied**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. How **easy** was it for your patient to follow the treatment?

Not at all easy										**Very easy**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

9. Did your patient's TMD diagnosis change since they enrolled in the study?

☐ Yes ----→ Go to question 10

☐ No ----→ **SKIP** to question 11

10. What are your patient's most current diagnoses?

Diagnoses **Please complete this to the best of your ability**	
Right TMJ pain (arthralgia)	☐ Yes ☐ No
Left TMJ pain (arthralgia)	☐ Yes ☐ No
Masticatory muscle pain (myalgia)	☐ Yes ☐ No
Masticatory muscle pain with referral (myofascial pain)	☐ Yes ☐ No
Headache related to TMD pain	☐ Yes ☐ No
TMJ disorder with clicking/popping noises (disc displacement with reduction)	☐ Yes ☐ No
TMJ disorder with crepitus noises (degenerative joint disease/osteoarthritis)	☐ Yes ☐ No
TMJ disorder with intermittent limited opening (disc displacement with reduction with intermittent locking)	☐ Yes ☐ No
TMJ disorder with persistent limited opening (disc displacement without reduction with limited opening)	☐ Yes ☐ No
TMJ disorder with locking wide open (dislocation)	☐ Yes ☐ No
Other(*please specify*):	☐ Yes ☐ No

11. Since the patient enrolled in the study, have you **changed** your initial treatment recommendations in any way? That is, are there any **NEW** treatments that you did not report in the *Initial Doctor Questionnaire*?

☐ Yes ----------→ Go to question 12

☐ No ----------→ **Skip** to question 15

NEW TREATMENT RECOMMENDATION(S)

12. What additional **NEW** treatment recommendations were **provided by you** or **were provided through a referral**?

Additional Treatments	**Recommended**
Self care	☐ Yes ☐ No
Medications	☐ Yes ☐ No
Intra-oral appliance	☐ Yes ☐ No
Herbs or supplements for pain	☐ Yes ☐ No
Jaw exercises	☐ Yes ☐ No
Self massage of jaw or temple	☐ Yes ☐ No
Massage therapy	☐ Yes ☐ No
Physical therapy	☐ Yes ☐ No
Chiropractic treatment	☐ Yes ☐ No
Psychological treatment (e.g., biofeedback, relaxation techniques)	☐ Yes ☐ No
Low level laser therapy	☐ Yes ☐ No
Trigger point injections	☐ Yes ☐ No
Botox injections	☐ Yes ☐ No
Acupuncture	☐ Yes ☐ No
Occlusal adjustment (bite adjustment)	☐ Yes ☐ No
Orthodontics for occlusal stabilization	☐ Yes ☐ No
Restorative dentistry for occlusal stabilization (e.g., crowns)	☐ Yes ☐ No
Full mouth reconstruction for occlusal stabilization	☐ Yes ☐ No
Jaw surgery (Orthognathic surgery)	☐ Yes ☐ No
TMJ arthrocentesis	☐ Yes ☐ No
TMJ arthroscopic surgery	☐ Yes ☐ No
TMJ open joint surgery (e.g., disc repair)	☐ Yes ☐ No
Other (*please specify*):	☐ Yes ☐ No

13. **How** many **different** types of intra-oral **appliances** have you given your patient since they were enrolled in this study?

0	1	2	3	4	5	6	7	8	9	10	More than 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

14. **Why** did you change the treatment?

Their diagnosis changed	☐ Yes ☐ No
Factor(s) that affect their pain has changed	☐ Yes ☐ No
They are not adhering to the current treatment recommendations	☐ Yes ☐ No
They are not getting better with the current treatment recommendations	☐ Yes ☐ No
They expressed interest in a new treatment	☐ Yes ☐ No
They can now afford more treatment	☐ Yes ☐ No
Other (*please specify*):	☐ Yes ☐ No

15. How would you describe the **change** (if any) in your patient's **jaw or temple pain** since the beginning of treatment?

Much Worse	Slightly Worse	No Change	Slightly Better	Much Better
☐	☐	☐	☐	☐

Thank you - Your time and expertise are appreciated!