Patient evaluation of TMD treatment progress

Patient Name: **Date:**

Appointment: **(circle one)**

Soft Guard	Follow up Weeks	1	2	6	13	26
TMD Appliance	Follow up Weeks	1	2	6	13	26

How are you doing? **(circle one)**

Much better - Better - Same - Worse - Much Worse

Are you happy with your progress so far?

❒ Yes, very much

❒ Yes

❒ Yes, pretty much

❒ I'm not sure

❒ No, I don't feel better

❒ No, I feel worse

Please describe how you feel?

Patient Signature:

Date:

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