SENSITIVE TEETH STUDY

Patient Pain Assessment – 4 Week (3rd Line Treatment)

Date Completed: ______/_____/______ 2011

We would like you to describe the pain from your sensitive tooth or teeth by answering the following questions. Please review the scale labels and then use a pen to mark the appropriate point on the scale that best describes your pain. Please use a vertical straight line. DO NOT USE AN ‘X’ MARK.

Example below:

Not painful

Most intense pain imaginable

1. Please describe the pain from your sensitive tooth or teeth that you have experienced in the past day (24 hours).

Not painful

Most intense pain imaginable

2. Please describe the sensation you have felt from your sensitive tooth or teeth in the past day (24 hours).

Not unpleasant

Most unpleasant sensation imaginable

For official use only:

SEE REVERSE
3. Now we would like you to describe the pain that you experienced in the past day (24 hours) related to your sensitive tooth or teeth. Please use a pen to mark a vertical straight line on the scales below to show how long your pain lasted (duration), how intense your pain was (intensity), how tolerable your pain was (tolerability) and what type of pain you had (description).

**DO NOT USE AN ‘X’ MARK.**

**Duration**

- No Pain
- Temporary
- Quick
- Lingering
- Chronic

For official use only: __________

**Intensity**

- No Pain
- Dim
- Dull
- Sharp
- Stabbing

For official use only: __________

**Tolerability**

- No Pain
- Tolerable
- Uncomfortable
- Unnerving
- Unbearable

For official use only: __________

**Description**

- No Pain
- Twinge
- Ache
- Throbbing
- Shooting

For official use only: __________
4. Are you using the product(s) recommended by your dentist at home?

☐ Yes
☐ No -----> Go to question 6
☐ My dentist did not recommend any product(s) to use at home -----> Go to question 6

5. If yes, how often are you using them?

☐ Weekly
☐ Daily
☐ Twice a day
☐ More than twice a day

6. Did your dentist recommend you stop or decrease any products and/or habits/activities?

☐ Yes-----> Go to question 7
☐ No -----> This form is completed

7. If yes, to what extent have you stopped or decreased these products or habits/activities?

☐ 100% of the time
☐ 50% of the time
☐ 25% of the time
☐ I have not stopped or decreased these products or habits at all

Thank you for completing the form!