Patient Before Visit Questionnaire (with variable scoring, references at end)

1. 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 it could be"? (current pain)

0	1	2	3	4	5	6	7	8	9	10
No pain										pain as bad as can be

2. In the past 7 days, 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 it could be"? (worst pain)

0	1	2	3	4	5	6	7	8	9	10
No pain										pain as bad as can be

3. In the past 7 days, on 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 it could be"? (that is, your usual pain at times you were experiencing pain) (average pain)

0	1	2	3	4	5	6	7	8	9	10
No pain										pain as bad as can be

A pain score of 7 or greater was considered severe. An overall measure of severe pain was defined as severe pain on all three assessments.

- 4. I feel that the treatment outcome for my tooth will turn out (**Treatment expectation: scored 1-4**): Poor, Fair, Good, Very good
- 5. To what degree are you afraid about receiving dental treatment today? (**Treatment fear: scored 1-5**):

Not at all afraid A little afraid Somewhat afraid Very afraid Extremely afraid

- 6. Medications: Have you taken any of the following medications or supplements in the past 7 days for the tooth that was treated today? (each yes or no)
 - Prescription pain medications Over-the-counter pain medications (a prescription was not needed) Antibiotics prescribed by your dentist Herbal medications

Questions 7-9 are related to any jaw or temple pain you may have had in the last 30 days (**TMD** screening questions)

7. On average, how long did any pain in your jaw or temple area on either side last? (dichotomized as any pain, yes/no, for TMD screening)

No pain From very brief to more than a week, but it does stop	Continuous
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- 8. Have you had any pain or stiffness in your jaw on awakening? Yes / No
- 9. Did the following activities change any pain (that is, make it better or make it worse) in your jaw or temple area on either side?
 - a) Chewing hard or tough food: Yes / No
 - b) Opening your mouth or moving your jaw forward or to the side: Yes / No
 - c) Jaw habits such as holding teeth together, clenching, grinding, or chewing gum: Yes / No
 - d) Other jaw activities such as talking, kissing, or yawning: Yes / No

Question 7 (as 1 for any pain and 0 for none), and 8, 9a-d, were summed, score range of 0-6; a score of 3 or higher was considered a **positive TMD** screen.

10. Everyone experiences painful situations at some point in their lives, such as headaches, tooth pain, joint or muscle pain. Please indicate the degree to which you have these thoughts, feelings when you're in pain (pain catastrophizing, each question scored 1-5, for a total score range of 2 – 10)

It is terrible and I think it is never going to get any better	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I feel I can't stand it any more	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

11. Over the past 2 weeks, how often have you been bothered by any of the following problems? (Depression score: each question scored 1-4; sum of the 2 questions, score range 2-8)

(Depression score, each question	Depression score: each question scored 1-4, sum of the 2 questions, score range 2-								
Little interest or pleasure in doing things	Not at all	Several days	More than half of the days	Nearly every day					
Feeling down, depressed or hopeless	Not at all	Several days	More than half of the days	Nearly every day					

12. Over the past 2 weeks, how often have you been bothered by any of the following problems? (Anxiety score: each question scored 1-4; sum of the 2 questions, score range 2-8)

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Feeling nervous, anxious or on	Not at all	Several	More than half	Nearly every						
edge	Not at all	days	of the days	day						
Not being able to stop or control	Not at all	Several	More than half	Nearly every						
worrying	NOT at all	days	of the days	day						

13. The next questions ask about your experiences including feelings and thoughts during the past month. In each case, mark how often you felt or thought a certain way. (**Stress**) In the past month, how often have you felt...

a) that you were unable to control the important things in your life	Never	Almose never	Sometimes	Fairy often	Often
b) confident about your ability to handle your personal problems?	Never	Almose never	Sometimes	Fairy often	Often
c) that things were going your way	Never	Almose never	Sometimes	Fairy often	Often
d) difficulties were piling up so high that you could not overcome them?	Never	Almose never	Sometimes	Fairy often	Often

(Scoring for stress. Questions a & d were scored 1-5, b & c were reversed coded so that higher numbers indicated more stress. The scores for the 4 questions were summed for the stress score, range of 4 to 20.)

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Pain measures

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