Patient Self-Assessment of Occlusal Condition

Patient Name ____________________________ Date ____________

The following questions have to do with your own perception of your bite. Please answer the questions as completely as possible. If you are unsure about an answer, please leave it blank. The doctor will review your answers with you and will help you respond to questions that you may not understand.

1. Please close your mouth to the position where your teeth fit together best, your “normal” bite. In most cases, this will be where your back teeth come together completely.
   Is it easy and comfortable for you to close with your back teeth together?
   □ Yes    If you answered “No,” what teeth touch when you close in a
   □ No    comfortable position? ______________________________

2. Now I’d like you to tap your back teeth together several times, tap, tap, tap. When you do that, do you feel your back teeth touching on both sides?
   □ Yes    If you answered “Yes,” continue to question #3
   □ No    If you answered “No,” please go to question #4

3. If you answered “Yes,” tap, tap, tap your teeth together again and tell me if it feels like you have good, solid, and equal contact on both sides in the back.
   □ Yes    If you answered “Yes,” please go to question #5
   □ No    If you answered “No,” please answer question #4

4. If you answered “No,” to either question #2 or #3, tell me where you do feel your teeth touching.

5. When you tap your back teeth together, as before, do you also feel your front teeth touching?
   □ Yes
   □ No

6. If you answered “Yes,” do you feel heavier contact on your front teeth or on your back teeth?
   □ Front
   □ Back

7. Finally, when you close your mouth with your back teeth together, how does it feel to you? Select one or more of the following:

   □ Comfortable
   □ Solid
   □ Even
   □ Uneven
   □ Uncomfortable
   □ Strained
   □ Painful

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