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| Name: |  | Phone: |  |
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| **Synergy Therapeutics M2 (Monitoring Myself) for the week preceding**  | **/ /**  |
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| *All questions should be answered with 0 being the best and 10 being the worst.* |
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| 1. | Do you feel that your bite is uneven or unstable? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 2. | Do you have any tooth or gum soreness? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 3. | Are you having problems with your appliance fitting well? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 4. | Are you unable to effectively clean your teeth or appliances? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 5. | Do you have sore neck muscles? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 6. | Do you have sore facial muscles? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 7. | Do you have pain between your shoulder blades? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 8. | Do you have hip or back pain? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 9. | Do you have clicking/popping/grating of your temporomandibular joint? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 10. | Do you have pain in your temporomandibular joint? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 11. | Do you feel that you have noise in or restrictions of movement of the joints in your neck? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 12. | Do you feel that your hip is out of alignment? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 13. | Are you having headaches? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 14. | Are you having migraines? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 15. | Are you having ringing in your ears, lack of balance or vertigo? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 16. | Are you experiencing anxiety more than usual? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 17. | Are you snoring? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 18. | Do you feel that you are getting inadequate sleep? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 19. | Are you experiencing morning headaches? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 20. | Are you unable to breathe through your nose? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 22. | How is your overall feeling of wellness? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 23. | Acidity level in the morning? |  | Saliva results  |  |  |
| 24. | How is your body coping with your chronic medical conditions? |  | 0 1 2 3 4 5 6 7 8 9 10 |
| 25. | How is your overall diet and digestion? |  | 0 1 2 3 4 5 6 7 8 9 10 |
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| What other health care providers have you seen since or treatments have you had since your last visit with us? |
| □ | Physical Therapy | □ | Pain Management | □ | Osteopath | □ | Dentist |
| □ | Massage Therapy | □ | MD *(Internist/Family Practice)* | □ | Chiropractor | □ | Other |
| Details: |  |
|  |  |  |
| Did this treatment help you? | □ | Yes | □ | No |
| Please describe: |  |
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|  |  |
| Since your last visit, when you’ve performed the two finger test at home, have you felt resistance on: □ both sides □ right side only □ left side only |
|  |  |
| What has been your schedule of wearing your appliance(s)? |  |
|  |  |
|  |  |
| What percentage do you comply with the above schedule? |  | % |
|  |  |
| Is there anything additional you feel is needed to assist in your recovery? |  |
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