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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)? | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| What percentage do you comply with the above schedule? | | | | | | | | | | | | | | | | | | | |  | | | | | % | | | | | |
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| Is there anything additional you feel is needed to assist in your recovery? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
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