



## Patient Survey – Immediately After Treatment

Please complete **before you leave the office today.**

Please mark answers with an "X" in the corresponding box. It is very important that the responses be recorded within the space allotted. **Example:**

When recording numerical responses, such as amounts or dates, one number should be entered into each box. **Example:**   /   / 20

1. How intense was your tooth pain **during** the root canal on a 0 to 10 scale, where 0 is "no pain" and 10 is "pain as bad as could be"?

No Pain

0

1

2

3

4

5

6

7

8

9

10

Pain as bad as could be

2. Please rate how numb your tooth felt during the root canal treatment (mark one).
- a.  The tooth was not numb enough.
  - b.  The tooth was numb enough.
  - c.  The tooth was too numb.
3. Please rate how your feelings of fear compared to the actual experience.
- a.  Does not apply – I was not afraid.
  - b.  The experience was *better* than I feared.
  - c.  The experience was about what I feared.
  - d.  The experience was *worse* than what I feared.