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: X

When recording numerical responses, such as amounts or dates, one number should be entered into each box. Example: 0 1 / 0 3 / 20 1 0

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"?

<table>
<thead>
<tr>
<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

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.