NAME: _____ **DATE:** _____

Please rank your concerns or anxiety over the dental procedures listed below by ranking them on the accompanying scale. Please fill in any additional concerns.

		Level of Concern or Anxiety			
		Low	Moderate	High	Don't Know
1	Sound or vibration of the drill	○	○	○	○
2	Not being numb enough	○	○	○	○
3	Dislike the numb feeling	○	○	○	○
4	Injection ("novocaine")	○	○	○	○
5	Probing to assess gum disease	○	○	○	○
6	The sound or feel of scraping during teeth cleaning	○	○	○	○
7	Gagging, for example during impressions of the mouth	○	○	○	○
8	X-rays	○	○	○	○
9	Rubber dam	○	○	○	○
10	Jaw gets tired	○	○	○	○
11	Cold air hurts teeth	○	○	○	○
12	Not enough information about procedures	○	○	○	○
13	Root canal treatment	○	○	○	○
14	Extraction	○	○	○	○
15	Fear of being injured	○	○	○	○
16	Panic attacks	○	○	○	○
17	Not being able to stop the dentist	○	○	○	○
18	Not feeling free to ask questions	○	○	○	○
19	Not being listened to or taken seriously	○	○	○	○
20	Being criticized, put down, or lectured to	○	○	○	○
21	Smells in the dental office	○	○	○	○
22	I am worried that I may need a lot of dental treatment	○	○	○	○
23	I am worried about the cost of the dental treatment I may need	○	○	○	○
24	I am worried about the number of appointments and the time that will be required for necessary appointments and treatment; time away from work, or the need for childcare or transportation	○	○	○	○
25	I am embarrassed about the condition of my mouth	○	○	○	○
26	I don't like feeling confined or not in control	○	○	○	○
Other (Use other side if needed):					

Delmarva Dental Services 1310 Belmont Ave Suite 301 Salisbury, MD 21804
410-742-3000

SUBMIT