Please Indicate An Answer For Each Behavior/Habits Question

Grind teeth:	☐ Present	☐ Past	☐ Never
Bite Cheek:	☐ Present	☐ Past	☐ Never
Tongue Thrust:	☐ Present	☐ Past	☐ Never
Mouth Breather:	☐ Present	☐ Past	☐ Never
Bulimia/Anorexia:	☐ Present	☐ Past	☐ Never
Cigar/Cigarette:	☐ Present	☐ Past	☐ Never
Pipe:	☐ Present	☐ Past	☐ Never
Bite Nails:	☐ Present	☐ Past	☐ Never
Smokeless Tobacco:	☐ Present	☐ Past	☐ Never
Thumb/Finger:	☐ Present	☐ Past	☐ Never
Toothpick/Stimulator:	☐ Present	☐ Past	☐ Never
Chewing Gum:	☐ Present	☐ Past	☐ Never
Candy:	☐ Present	☐ Past	☐ Never
Soft Drinks:	☐ Present	☐ Past	☐ Never
Other Beverages:	☐ Present	☐ Past	☐ Never

Soft Drink Type or Other Beverage Description: _____

Are Your Teeth Sensitive To:

Hot or Cold:	☐ Present	☐ Past	☐ Never
Biting/Chewing:	☐ Present	☐ Past	☐ Never
Sweets:	☐ Present	☐ Past	☐ Never

Have You Ever Had:

Orthodontic Treatment:	☐ Present	☐ Past	☐ Never
A Bite Plate or Guard:	☐ Present	☐ Past	☐ Never
Periodontic Treatment:	☐ Present	☐ Past	☐ Never
Oral Surgery:	☐ Present	☐ Past	☐ Never
Serious Injury to Mouth or Head:	☐ Present	☐ Past	☐ Never