



SKULL-OCCLUSION-POSTURAL MULTIFUNCTIONAL HARMONIZERS

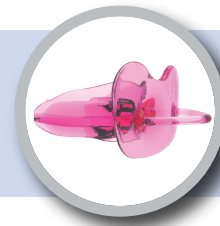
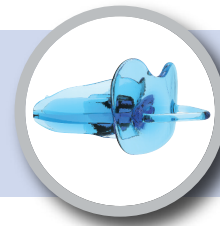


ORTHODONTIC SURVEY FOR AMCOP THERAPY

Amcopp Questionario v2_12-2018 EN

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NAME & SURNAME.....
 DATE OF BIRTH.....
 AGE.....
 CITY.....
 GENDER M F

What is the main purpose of this examination?

- 1. simple check
- 2. prevention
- 3. improve aesthetics
- 4. chewing troubles
- 5. respiratory issues
- 6. phonetic issues
- 7. postural issues
- 8. other.....

Which of these do you usually eat?

- 1. snacks
 - 2. candies
 - 3. other
- How often?
- most days
 - rarely
 - never

How often do you brush your teeth?

- 1. every evening
- 2. every morning
- 3. after each meal
- 4. occasionally

Are you used to chew up pens or pencils?

- 1. most days
- 2. sometimes
- 3. never

Does your child suck his/her thumb or a pacifier?

- 1. very often
- 2. just to fall asleep
- 3. never
- 4. He/she did it in the past (for how long? _____)

Do you gnash your teeth?

- 1. yes
- 2. no
- 3. sometimes
- 4. I don't know

Do you put your tongue between your arches?

- 1. yes
- 2. no
- 3. sometimes

Does your tongue rest on the upper palatal arch?

- 1. yes
- 2. no

Do you breathe with your mouth open?

- 1. often during the day
- 2. sometimes at night
- 3. only when I have a cold

Do you usually suffer from

- 1. cold
- 2. sore throat
- 3. tonsillitis
- 4. snoring

Do you suffer from

- 1. adenoids
- 2. tonsillitis
- 3. otitis
- 4. asthma
- 5. allergies
- 6. neck pain
- 7. shoulder pain
- 8. facial muscles tenseness
- 9. muscle fatigue in the morning
- 10. facial twitches
- 11. eye twitches
- 12. verbal dysfunction (stuttering)
- 13. phonetic issues

How often do you suffer from headaches?

- 1. never
- 2. often
- 3. just in specific days

Does the area around your ears hurt when you move your jaws?

- 1. in the past
- 2. sometimes
- 3. always
- 4. just some crunching
- 5. loud noise
- 6. pain
- 7. difficulties in opening my mouth
- 8. difficulties in closing my mouth
- 9. yawning
- 10. every time I open/close my mouth
- 11. chewing hard food
- 12. mainly on the right side
- 13. mainly on the left side
- 14. both sides

Have you ever worn any orthodontic appliances?

- 1. yes
 - 2. no
- For how long?

How would you describe your child's behavior

- 1. lively
- 2. extroverted
- 3. peaceful
- 4. introverted
- 5. impatient
- 6. obedient

Does any of your relatives suffer from malocclusion?

- 1. yes (grandparents, parents, siblings)
- 2. no
- 3. I do not know

His/Her Birth was

- 1. premature
- 2. punctual
- 3. induced

At nighttime

- | | | | |
|--|-----|----|--------|
| <input type="checkbox"/> 1. trouble sleeping | Yes | No | Rarely |
| <input type="checkbox"/> 2. thirst | Yes | No | Rarely |
| <input type="checkbox"/> 3. salivation | Yes | No | Rarely |
| <input type="checkbox"/> 4. sweating | Yes | No | Rarely |
| <input type="checkbox"/> 5. snoring | Yes | No | Rarely |
| <input type="checkbox"/> 6. sleep apnea | Yes | No | Rarely |

In the daytime

- | | | | |
|---|-----|----|--------|
| <input type="checkbox"/> 1. tiredness | Yes | No | Rarely |
| <input type="checkbox"/> 2. trouble breathing | Yes | No | Rarely |
| <input type="checkbox"/> 3. nosebleed | Yes | No | Rarely |
| <input type="checkbox"/> 4. trouble focusing | Yes | No | Rarely |
| <input type="checkbox"/> 5. open mouth | Yes | No | Rarely |
| <input type="checkbox"/> 6. headaches | Yes | No | Rarely |