AMCOP®

BIO ACTIVATOR

By Micerium

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AMCOP®

BIO ACTIVATOR

SKELETAL- OCCLUSAL- POSTURAL MULTIFUNCTIONAL HARMONIZERS

ORTHODONTIC SURVEY FOR AMCOP THERAPY

ORTHODONTIC SURVEY
FOR AMCOP THERAPY

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 twiches
- ☐ 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

- ☐ 1. trouble sleeping Yes No Rarely
- ☐ 2. thirst Yes No Rarely
- ☐ 3. salivation Yes No Rarely
- ☐ 4. sweating Yes No Rarely
- ☐ 5. snoring Yes No Rarely
- ☐ 6. sleep apnea Yes No Rarely

In the daytime

- ☐ 1. tireness Yes No Rarely
- ☐ 2. trouble breathing Yes No Rarely
- ☐ 3. nosebleed Yes No Rarely
- ☐ 4. trouble focusing Yes No Rarely
- ☐ 5. open mouth Yes No Rarely
- ☐ 6. headaches Yes No Rarely

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