Patient Name	
Date	
Signature	
Name of parent/guardian if applicable	

CAN YOU TELL US HOW ANXIOUS YOU GET, IF AT ALL, WITH YOUR DENTAL VISIT?

PLEASE INDICATE BY INSERTING 'X' IN THE APPROPRIATE BOX

1. **If you went to your Dentist for TREATMENT TOMORROW, how would you feel?**

Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

2. **If you were sitting in the WAITING ROOM (waiting for treatment), how would you feel?**

Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

3. **If you were about to have a TOOTH DRILLED, how would you feel?**

Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

4. **If you were about to have your TEETH SCALED AND POLISHED, how would you feel?**

Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

5. **If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth, how would you feel?**

Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

OFFICE USE ONLY Total Score _____