Quality of Life Scale

Patient Name:_____Date:_____Tx Stage:_____

Underline the issues and circle the rating:
1=not a problem, 10 = a problem that MUST be addressed

1. Breathing through the nose (congestion, frequent colds, infections)

1 2 3 4 5 6 7 8 9 10

2. Lips together at rest (open mouth, lips apart at rest, chapped lips)

1 2 3 4 5 6 7 8 9 10

3. Chew and swallowing (uses facial muscles, sloppy, noisy, drooling)

1 2 3 4 5 6 7 8 9 10

4. Sitting and standing posture (slouching, neck extended forward, shoulders hunched)

1 2 3 4 5 6 7 8 9 10

5. Eating and nutrition status (picky eating, difficulty chewing, poor nutrition; pain)

1 2 3 4 5 6 7 8 9 10

6. Allergies (food, seasonal, animal, skin)

1 2 3 4 5 6 7 8 9 10

7. Good Sleep (restless, snoring, messing bed, falling asleep, parasomnias)

1 2 3 4 5 6 7 8 9 10

8. Breathing while sleeping (snoring, heavy breathing, open mouth position)

1 2 3 4 5 6 7 8 9 10

9. Tooth grinding (bruxing, clenching, daytime, nighttime)

1 2 3 4 5 6 7 8 9 10

10. Behavioral issue at home/school (attention, learning, behaviors, hyper, sleepy)

1 2 3 4 5 6 7 8 9 10