Name _____

Dental Treatment Anxiety Scale

We strive to make your experience in our office as pleasant as possible. In order for our staff and doctors to better handle any anxiety or concern you may have about having dental treatment: please take a few minutes to answer the following questions by circling your response on the graded scale.

1 not nervous or anxious ------to----- 5 very anxious or nervous.

1. Entering a dental office 1___2___3___4___5 (not ... very)
2. Smell or odor of dental/medical environment 1___2___3___4___5
3. Sitting in the dental chair 1___2___3___4___5
4. Having an injection of local anesthetic 1___2___3___4___5
5. Noise of drill or other instruments 1___2___3___4___5
6. Length of time in chair for work to be done 1___2___3___4___5
7. Lack of control over procedure or treatment 1___2___3___4___5
8. Concern that it will hurt while having work done 1___2___3___4___5
9. Concern that you might get AIDS 1___2___3___4___5
10. Embarrassed about present dental condition 1___2___3___4___5
11. Concern about paying for needed treatment 1___2___3___4___5
12. Other concerns you may have: _____

_____