UNCLENCH

Thank you for registering for an assessment and potential treatment at *UN*CLENCH. With this letter, we aim to inform you about the associated procedures. We recommend keeping this letter for future reference.

Below, you will find an overview of the procedures involved in the initial assessment, including potential costs, as well as a brief explanation of the treatment options available at our practice.

The **'Diagnostic Questionnaire'** is designed to provide the dentist with insight into your complaint(s) for which you are seeking treatment. The questionnaire also gathers information about various factors that may contribute to your complaint(s) and maps out your medical history. Based on the information from the referral letter and this questionnaire, the dentist will determine the most suitable approach to address your complaint(s). Therefore, it is important that you **complete the questionnaire** in **Adobe Reader** and **return it via email before the clinical assessment**. Completing the questionnaire is necessary to schedule an initial appointment. Once we have received the questionnaire, we will contact you to arrange an appointment.

Procedures

To ensure a smooth process, we kindly ask you to take note of the following points:

- This consultation is intended to establish a diagnosis. If additional investigations are required or if treatment is initiated, follow-up appointments will be scheduled with you.
- Do you experience pain in your chewing system? If so, please **refrain** from taking **painkillers** at least **8 hours prior** to the consultation.
- If you have a **splint** or **night guard**, could you please **bring** it to your appointment?
- Unable to attend your appointment? Please inform us by phone **at least 48 hours** in advance via **020 308 6055** (Monday – Friday).
- Appointments that are missed without prior notice will be charged. If you fail to show up twice without informing us, we will regrettably have to discontinue your treatment.

You will find a cost overview in this letter for the diagnostic consultation and any potential treatment.

For further questions, you can reach us at **020 308 6055**, or by email at **gnathologie@kaakchirurgie-zuidas.nl**

We hope this letter provides you with sufficient information.

Kind regards,

Anna Koevoets

Dentist – Orofacial Pain & Dysfunction specialist (NL: tandarts – gnatholoog)

BIG registration number: 79929027002

The Dutch Healthcare Authority (NZa) has set the rate structure and associated rates for dental treatments for 2026.

Diagnostic consultation for Temporomandibular Dysfunction and Orofacial Pain.

The costs of the initial investigation include:

- Panoramic jaw X-ray, performance code X21: €90.02
- Functional examination of the chewing system, performance code G21: €135.03
- Extended OPD investigation, performance code G22: €270.06

* Any additional costs will always be communicated to you. For children and young people up to 18 years old, the Basic insurance covers most dental costs.

The reimbursement for the diagnostic consultation depends on the policy conditions of your health insurer.

After the initial investigation, I will request authorization from your health insurer to cover the costs under the Basic insurance, where applicable. For specific questions about reimbursement and any personal contributions, we advise you to contact your health insurer.

UNCLENCH

Before you complete the questionnaire, we kindly ask you to sign this form. The intake can only be scheduled if you agree to the associated costs.

You have read the information about the costs for the Orofacial Pain and Dysfunction treatment, and you agree to the costs of the initial investigation. If you do not agree, the first appointment cannot take place.

1	I have read the above and I agree.	Choose an option:
2	I give permission for data regarding diagnostics and treatment planning to be exchanged with my dentist, general practitioner and/ or other referrer.	Choose an option:
3	I consent to the exchange of psychosocial information with my general practitioner and other involved healthcare providers within a potential treatment plan for my complaints, to ensure I receive the best possible care.	Choose an option:
4	To ensure my consultations are documented as accurately and carefully as possible, I give permission for the use of audio recording and automatic transcription during consultations. This is used solely to support the careful preparation of the consultation notes. The audio recording and transcript are deleted after each consultation; only the final written report remains part of my patient record.	Choose an option:
5	I agree to the anonymous use of the data from this questionnaire and from clinical research for scientific purposes.	Choose an option:

Patient's name:

Date of birth:

Date:

Patient's signature:

Contact details practitioners

Name dentist	
Address dentist	
Email address dentist	
Name general practitioner (GP)	
Address general practitioner (GP)	
Email address general practitioner (GP)	

Previous treatments

Have you previously received treatment for the complaint for which you registered?	Choose an option:
Type of treatment and specialist	
From when to when	
Effectiveness of the treatment	
Type of treatment and specialist	
From when to when	
Effectiveness of the treatment	
Type of treatment and specialist	
From when to when	
Effectiveness of the treatment	
Type of treatment and specialist	
From when to when	
Effectiveness of the treatment	
Type of treatment and specialist	
From when to when	
Effectiveness of the treatment	

Have you ever received psychological treatment?	Choose an option:
Psychologist or psychiatrist?	
From when to when	

Health check questionnaire dentistry / Adult

male/female

Why is this form important for your dentist or dental hygienist? Problems in your mouth can be caused by illness or use of medication. When you are ill or use medication, this can limit dental treatment or it can be necessary to take precautions. It is very important that your dentist takes this into account. Always inform your dentist if anything changes in your health or use of medication. Your details are strictly confidential and will be treated with the utmost respect according to the privacy legislation. Please bring a recent form of medication with you when you have an appointment with the dentist. Your pharmacy can provide you this form.

Have there been any changes in your health over the past couple of months?	No	Yes > if so, what?
Are you currently receiving treatment from a doctor or medical specialist?	No	Yes > please specify
Have you been admitted to hospital in the past years?	No	Yes > what for?
Have you ever had a serious disease?	No	Yes > please specify
Do you have any allergies?	No	Yes > please specify
Have you had a heart attack/cardiac infarction?	No	Yes > when?
Do you have palpitations?	No	Yes
Are you receiving treatment for high blood pressure?	No	Yes > Pressure……. Systolic…….
Do you experience chest pain during exercise and/or emotions?	No	Yes
Do you have swollen ankles/feet?	No	Yes
Are you short of breath during exercises?	No	Yes
Are you short of breath when you lay down in bed?	No	Yes
Do you have a defective or an artificial heart valve?	No	Yes
Do you have a congenital heart defect?	No	Yes
Do you have a pacemaker, neurostimulator or ICD?	No	Yes
Are you currently being monitored by the thrombosis services?	No	Yes
Have you ever fainted at the dentist or during a medical examination?	No	Yes
Do you suffer from hyperventilation?	No	Yes
Do you suffer from epilepsy/falling disease?	No	Yes
Have you ever suffered a cerebral haemorrhage or a stroke (or TIA)?	No	Yes
Do you suffer from pulmonary symptoms such as asthma, bronchitis or chronic cough?	No	Yes > are you short of breath? No/Yes
Do you suffer from diabetes?	No	Yes > do you use insulin? No/Yes
Do you suffer from anaemia?	No	Yes
Have you ever suffered from extensive bleeding after tooth extraction, surgery or injuries?	No	Yes
Do you have hepatitis, yellow fever or any other liver disease?	No	Yes
Do you have a kidney disease?	No	Yes
Do you have chronic stomach complaints?	No	Yes

Do you suffer from a thyroid disorder?	No	Yes
Do you suffer from rheumatism and/or chronic arthralgia?	No	Yes
Have you ever used in the past medication for osteoporosis such as Denosumab or bisphosphonate?	No	Yes > please specify
Do you have a contagious disease?	No	Yes > please specify
Have you ever received radio therapy for a tumour in head and/or neck?	No	Yes
Do you smoke and/or use an e-smoker/vape?	No	Yes > how many per day?
Do you use drugs?	No	Yes > what?
Do you drink alcohol?	No	Yes > how many glasses per week?
Do you use drugs or have you ever used drugs?	No	Yes > please specify
@ women: are you pregnant?	No	Yes > when is your due date?
Do you have a disease that is not mentioned in this list?	No	Yes > please specify
Do you use medication?	No	Yes >

If so, which medicines do you use?

Notes/Remarks:

Date:

TMD-PAIN SCREENER

1. In the last 30 days, how long did any pain last in your jaw or temple area on either side?
   - ◯ a. No pain
   - ◯ b. Pain comes and goes
   - ◯ c. Pain is always present

2. In the last 30 days, have you had pain or stiffness in your jaw on awakening?
   - ◯ a. No
   - ◯ b. Yes

3. In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw or temple area on either side?

   A. Chewing hard or tough food
   - ◯ a. No
   - ◯ b. Yes

   B. Opening your mouth or moving your jaw forward or to the side
   - ◯ a. No
   - ◯ b. Yes

   C. Jaw habits such as holding teeth together, clenching, grinding, or chewing gum
   - ◯ a. No
   - ◯ b. Yes

   D. Other jaw activities such as talking, kissing, or yawning
   - ◯ a. No
   - ◯ b. Yes

Diagnostic Criteria for Temporomandibular Disorders
Symptom Questionnaire

Complaint(s) for which I am seeking help:

PAIN

1. Have you ever had pain in your jaw, temple, in the ear, or in front of the ear on either side? — No ◯ Yes ◯

If you answered NO, then skip to Question 5.

2. How many years or months ago did your pain in the jaw, temple, in the ear, or in front of the ear first begin? _____years _____months

3. In the last 30 days, which of the following best describes any pain in your jaw, temple, in the ear, or in front of the ear on either side?

Select ONE response.

- ◯ No pain
- ◯ Pain comes and goes
- ◯ Pain is always present

If you answered NO to Question 3, then skip to Question 5.

4. In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw, temple, in the ear, or in front of the ear on either side?

		No	Yes
A.	Chewing hard or tough food	◯	◯
B.	Opening your mouth, or moving your jaw forward or to the side	◯	◯
C.	Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum	◯	◯
D.	Other jaw activities such as talking, kissing, or yawning	◯	◯

HEADACHE

5. In the last 30 days, have you had any headaches that included the temple areas of your head? — No ◯ Yes ◯

If you answered NO to Question 5, then skip to Question 8.

6. How many years or months ago did your temple headache first begin? _____years _____months

7. In the last 30 days, did the following activities change any headache (that is, make it better or make it worse) in your temple area on either side?

		No	Yes
A.	Chewing hard or tough food	◯	◯
B.	Opening your mouth, or moving your jaw forward or to the side	◯	◯
C.	Jaw habits such as holding teeth together, clenching/grinding, or chewing gum	◯	◯
D.	Other jaw activities such as talking, kissing, or yawning	◯	◯

JAW JOINT NOISES

		No	Yes	Office use R	L	DNK
8.	In the last 30 days, have you had any jaw joint noise(s) when you moved or used your jaw?	○	○	☐	☐	☐

CLOSED LOCKING OF THE JAW

9.	Have you ever had your jaw lock or catch, even for a moment, so that it would not open ALL THE WAY?	○	○	☐	☐	☐
	If you answered NO to Question 9 then skip to Question 13.					
10.	Was your jaw lock or catch severe enough to limit your jaw opening and interfere with your ability to eat?	○	○	☐	☐	☐
11.	In the last 30 days, did your jaw lock so you could not open ALL THE WAY, even for a moment, and then unlock so you could open ALL THE WAY?	○	○	☐	☐	☐
	If you answered NO to Question 11 then skip to Question 13.					
12.	Is your jaw currently locked or limited so that your jaw will not open ALL THE WAY?	○	○	☐	☐	☐

OPEN LOCKING OF THE JAW

13.	In the last 30 days, when you opened your mouth wide, did your jaw lock or catch even for a moment such that you could not close it from this wide open position?	○	○	☐	☐	☐
	If you answered NO to Question 13 then you are finished.					
14.	In the last 30 days, when you jaw locked or caught wide open, did you have to do something to get it to close including resting, moving, pushing, or maneuvering it?	○	○	☐	☐	☐

Graded Chronic Pain Scale Version 2.0

1. On how many days in the **last 6 months** have you had facial pain? _____ Days

2. How would you rate your facial pain **RIGHT NOW?** Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

3. In the LAST 30 DAYS, how would you rate your **WORST** facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

4. In the LAST 30 DAYS, **ON AVERAGE**, how would you rate your facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be". [That is, *your usual pain* at times you were in pain.]

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

5. In the LAST 30 DAYS, how many days did your facial pain keep you from doing your **USUAL ACTIVITIES** like work, school, or housework? (every day = 30 days)

_____ Days

6. In the LAST 30 DAYS, how much has facial pain interfered with your **DAILY ACTIVITIES**? Use a 0-10 scale, where 0 is “no interference: and 10 is “unable to carry on any activities”.

No interference — Unable to carry on any activities

0 1 2 3 4 5 6 7 8 9 10

7. In the LAST 30 DAYS, how much has facial pain interfered with your **RECREATIONAL, SOCIAL AND FAMILY ACTIVITIES**? Use the same scale, where 0 is “no interference: and 10 is “unable to carry on any activities”.

No interference — Unable to carry on any activities

0 1 2 3 4 5 6 7 8 9 10

8. In the LAST 30 DAYS, how much has facial pain interfered with your **ABILITY TO WORK**, including housework? Use the same scale, where 0 is “no interference: and 10 is “unable to carry on any activities”.

No interference — Unable to carry on any activities

0 1 2 3 4 5 6 7 8 9 10

Pain intensity score 0 Pain interference score 0

Only the Adobe program automatically calculates the questionnaire scores; otherwise.

Jaw Functional Limitation Scale – 8

For each of the items below, please indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, leave the item blank.

		No limitation										Severe Limitation
1.	Chew tough food	0	1	2	3	4	5	6	7	8	9	10
2.	Chew chicken (e.g., prepared in oven)	0	1	2	3	4	5	6	7	8	9	10
3.	Eat soft food requiring no chewing (e.g., mashed potatoes, apple sauce, pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10
4.	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10
5.	Swallow	0	1	2	3	4	5	6	7	8	9	10
6.	Yawn	0	1	2	3	4	5	6	7	8	9	10
7.	Talk	0	1	2	3	4	5	6	7	8	9	10
8.	Smile	0	1	2	3	4	5	6	7	8	9	10

Only the Adobe program automatically calculates the questionnaire scores; otherwise, you need to add them up yourself.

Total 0

GAD - 7

Over the last 2 weeks, how often have you been bothered by the following problems? Place a check mark in the box to indicate your answer.

		Not at all	Several days	More than half the days	Nearly every day
		0	1	2	3
1.	Feeling nervous, anxious or on edge	☐	☐	☐	☐
2.	Not being able to stop or control worrying	☐	☐	☐	☐
3.	Worrying too much about different things	☐	☐	☐	☐
4.	Trouble relaxing	☐	☐	☐	☐
5.	Being so restless that it is hard to sit still	☐	☐	☐	☐
6.	Becoming easily annoyed or irritable	☐	☐	☐	☐
7.	Feeling afraid as if something awful might happen	☐	☐	☐	☐

TOTAL SCORE = 0

Only the Adobe program automatically calculates the questionnaire scores; otherwise, you need to add them up yourself.

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Health Questionnaire - 9

Over the last 2 weeks, how often have you been bothered by the following problems?
Please place a check mark in the box to indicate your answer.

		Not at all	Several days	More than half the days	Nearly every day
		0	1	2	3
1.	Little interest or pleasure in doing things	☐	☐	☐	☐
2.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
3.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4.	Feeling tired or having little energy	☐	☐	☐	☐
5.	Poor appetite or overeating	☐	☐	☐	☐
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9.	Thinking that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

TOTAL SCORE = 0

Only the Adobe program automatically calculates the questionnaire scores; otherwise, you need to add them up yourself.

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult
☐	☐	☐	☐

Patient Health Questionnaire-15: Physical Symptoms

During the last 4 weeks, how much have you have been bothered by any of the following problems? Please place a check mark in the box to indicate your answer.

		Not bothered	Bothered a little	Bothered a lot
		0	1	2
1.	Stomach pain	☐	☐	☐
2.	Back pain	☐	☐	☐
3.	Pain in your arms, legs, or joints (knees, hips, etc)	☐	☐	☐
4.	Menstrual cramps or other problems with your periods [women only]	☐	☐	☐
5.	Headaches	☐	☐	☐
6.	Chest pain	☐	☐	☐
7.	Dizziness	☐	☐	☐
8.	Fainting spells	☐	☐	☐
9.	Feeling your heart pound or race	☐	☐	☐
10.	Shortness of breath	☐	☐	☐
11.	Pain or problems during sexual intercourse	☐	☐	☐
12.	Constipation, loose bowels, or diarrhea	☐	☐	☐
13.	Nausea, gas, or indigestion	☐	☐	☐
14.	Feeling tired or having low energy	☐	☐	☐
15.	Trouble sleeping	☐	☐	☐

TOTAL SCORE = 0

Only the Adobe program automatically calculates the questionnaire scores; otherwise, you need to add them up yourself.

The Oral Behavior Checklist

How often do you do each of the following activities, based on **the last month**? If the frequency of the activity varies, choose the higher option. Please place a (√) response for each item and do not skip any items.

	Activities During Sleep	None of the time	< 1 Night /Month	1-3 Nights /Month	1-3 Nights /Week	4-7 Nights/ Week	
1	Clench or grind teeth **when asleep**, based on any information you may have	○	○	○	○	○	
2	Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side)	○	○	○	○	○	0
	Activities During Waking Hours	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**	
3	Grind teeth together **during waking hours**	○	○	○	○	○	
4	Clench teeth together **during waking hours**	○	○	○	○	○	
5	Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth)	○	○	○	○	○	
6	Hold, tighten, or tense muscles without clenching or bringing teeth together	○	○	○	○	○	
7	Hold or jut jaw forward or to the side	○	○	○	○	○	
8	Press tongue forcibly against teeth	○	○	○	○	○	
9	Place tongue between teeth	○	○	○	○	○	
10	Bite, chew, or play with your tongue, cheeks or lips	○	○	○	○	○	
11	Hold jaw in rigid or tense position, such as to brace or protect the jaw	○	○	○	○	○	
12	Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc	○	○	○	○	○	
13	Use chewing gum	○	○	○	○	○	
14	Play musical instrument that involves use of mouth or jaw (for example, woodwind, brass, string instruments)	○	○	○	○	○	
15	Lean with your hand on the jaw, such as cupping or resting the chin in the hand	○	○	○	○	○	
16	Chew food on one side only	○	○	○	○	○	
17	Eating between meals (that is, food that requires chewing)	○	○	○	○	○	
18	Sustained talking (for example, teaching, sales, customer service)	○	○	○	○	○	
19	Singing	○	○	○	○	○	
20	Yawning	○	○	○	○	○	
21	Hold telephone between your head and shoulders	○	○	○	○	○	0

Only the Adobe program automatically calculates the questionnaire scores; otherwise, you need to add them up yourself.

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of dozing** **0 1 2 3**
Sitting and reading	○ ○ ○ ○
Watching TV	○ ○ ○ ○
Sitting, inactive in a public place (e.g. theatre or meeting)	○ ○ ○ ○
As a passenger in a car for an hour without a break	○ ○ ○ ○
Lying down to rest in the afternoon when circumstances permit	○ ○ ○ ○
Sitting and talking to someone	○ ○ ○ ○
Sitting quietly after a lunch without alcohol	○ ○ ○ ○
In a car, while stopped for a few minutes in the traffic	○ ○ ○ ○
	Total 0

Johns, M. W. (1991). A new method for measuring daytime sleepiness: the Epworth sleepiness scale. *Sleep*, *14*(6), 540-545. https://doi.org/10.1093/sleep/14.6.540

Trauma Screening Questionnaire (TSQ)

Choose one option:

Your own reactions now to the traumatic event. Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your persona reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following at least twice in the past week.

Situation	**No**	**Yes**
Upsetting thoughts or memories about the event that have come into your mind against your will	○	○
Upsetting dreams about the event	○	○
Acting or feeling as though the event were happening again	○	○
Feeling upset by reminders of the event	○	○
Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event	○	○
Difficulty falling or staying asleep	○	○
Irritability or outbursts of anger	○	○
Difficulty concentrating	○	○
Heightened awareness of potential dangers to yourself and others	○	○
Being jumpy or being startled at something unexpected	○	○

Total 0

Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S., & Foa, E. B. (2002). Brief screening instrument for post-traumatic stress disorder. *Br J Psychiatry*, *181*, 158-162. https://doi.org/10.1017/s0007125000161896

Ten-Item Personality Inventory (TIPI)

Here are a number of personality traits that may or may not apply to you. Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement. You should rate the extent to which the pair of traits applies to you, even if one characteristic applies more strongly than the other.

I see myself as…	**Disagree strongly (1)**	**Disagree moderately (2)**	**Disagree a little (3)**	**Neither agree nor disagree (4)**	**Agree a little (5)**	**Agree moderately (6)**	**Agree strongly (7)**
Extraverted, enthusiastic.	○	○	○	○	○	○	○
Critical, querrelsome.	○	○	○	○	○	○	○
Dependable, self-disciplined.	○	○	○	○	○	○	○
Anxious, easily upset.	○	○	○	○	○	○	○
Open to new experience, complex.	○	○	○	○	○	○	○
Reserved, quiet.	○	○	○	○	○	○	○
Sympathetic, warm.	○	○	○	○	○	○	○
Disorganized, careless.	○	○	○	○	○	○	○
Calm, emotionally stable.	○	○	○	○	○	○	○
Conventional, uncreative.	○	○	○	○	○	○	○

Gosling S. D., Rentfrow P. J., Swann W. B. (2003). A very brief measure of the big-five personality domains. J. Res. Pers. 37, 504–528. doi: 10.1016/s0092-6566(03)00046-1

Only the Adobe program automatically calculates the questionnaire scores; otherwise, you need to add them up yourself.

Coping Inventory for Stressful Situations (CISS-21)

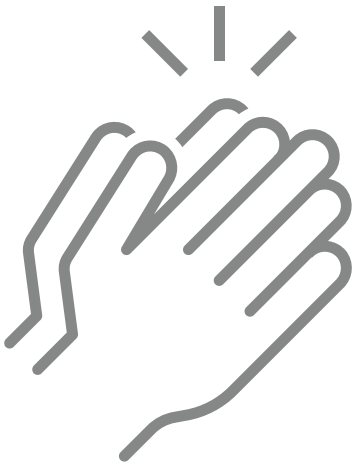
Please read each of the following statements carefully and indicate how often you use this type of response when experiencing stressful situations. There are no right or wrong answers – please respond as honestly and spontaneously as possible.

	Not at all (1)	Very little (2)	Moderately (3)	A lot (4)	Very much (5)
1. *Take some time off and get away from the situation*	○	○	○	○	○
2. *Focus on the problem and see how I can solve it*	○	○	○	○	○
3. *Blame myself for having gotten into this situation*	○	○	○	○	○
4. *Treat myself to a favorite food or snack*	○	○	○	○	○
5. *Feel anxious about not being able to cope*	○	○	○	○	○
6. *Think about how I solved similar problems*	○	○	○	○	○
7. *Visit a friend*	○	○	○	○	○
8. *Determine a course of action and follow it*	○	○	○	○	○
9. *Buy myself something*	○	○	○	○	○
10. *Blame myself for being too emotional about the situation*	○	○	○	○	○
11. *Work to understand the situation*	○	○	○	○	○
12. *Become very upset*	○	○	○	○	○
13. *Take corrective action immediately*	○	○	○	○	○
14. *Blame myself for not knowing what to do*	○	○	○	○	○
15. *Spend time with a special person*	○	○	○	○	○
16. *Think about the event and learn from my mistakes*	○	○	○	○	○
17. *Wish that I could change what had happened or how I felt*	○	○	○	○	○
18. *Go out for a snack or meal*	○	○	○	○	○
19. *Analyze my problem before reacting*	○	○	○	○	○
20. *Focus on my general inadequacies*	○	○	○	○	○
21. *Phone a friend*	○	○	○	○	○

Endler, N. S., & Parker, J. D. A. (1994). Assessment of multidimensional coping: Task, emotion, and avoidance strategies. Psychological Assessment, 6(1), 50–60. doi:10.1037/1040-3590.6.1.50

Additional comments:

Thank you for filling in the questionnaires



UNCLENCH

0 Pain intensity

0 Pain interference

0 GAD-7

0 PHQ-9

0 PHQ-15

0 OBC asleep

0 OBC awake

0 ESS

0 TSQ

0 Extraversion

0 Agreeableness

0 Conschientiousness

0 Emotional Stability

0 Openness to Experiences

0 Task-oriented coping

0 Emotion-oriented coping

0 Avoidance coping

Kaakchirurgie Zuidas