

**PRE-APPOINTMENT INFORMATION
PARENT/GUARDIAN QUESTIONNAIRE**
Sparkles for Special Teeth Program

Date: _____

Child's Name: _____ Age: _____

Date of Birth: ___/___/___ Physician(s): _____

Special Needs Diagnosis: _____ Developmental Age: _____

Describe any previous dental experiences and how your child coped: _____

My child needs: (check whichever apply)

- | | |
|---|--|
| <input type="checkbox"/> a routine exam | <input type="checkbox"/> "a lot of work" |
| <input type="checkbox"/> a filling | <input type="checkbox"/> orthodontic treatment |
| <input type="checkbox"/> a cleaning | <input type="checkbox"/> an extraction |

My child will probably be:

- | | |
|--|--|
| <input type="checkbox"/> age appropriate | <input type="checkbox"/> aggressive |
| <input type="checkbox"/> playful | <input type="checkbox"/> aloof |
| <input type="checkbox"/> non-focused | <input type="checkbox"/> short in attention span |
| <input type="checkbox"/> wiggly | <input type="checkbox"/> combative |

Management techniques I would like the doctor to use:

- | | |
|---|--|
| <input type="checkbox"/> sedation | <input type="checkbox"/> restraint |
| <input type="checkbox"/> short, multiple visits | <input type="checkbox"/> general anesthesia to finish treatment in one visit |

I prefer to be in the waiting room ___ treatment room ___ during my child's dental visit because: _____

MEDICAL INFORMATION:

CURRENT MEDICATIONS: _____

DOES YOUR CHILD HAVE SEIZURES? _____ ARE THEY CONTROLLED? _____
DATE OF LAST SEIZURE _____

ALLERGIES (please list) _____

ACTIVITIES OF DAILY LIFE:

BRUSHING:

WHO: _____ HOW LONG: _____ HOW OFTEN: _____

MANUAL or ELECTRIC TOOTHBRUSH _____

FLOSSING:

WHO: _____ HOW OFTEN: _____

TOILET:

INDEPENDENT _____ NEEDS ASSISTANCE _____

EATING:

INDEPENDENT _____ NEEDS ASSISTANCE _____

TAKING MEDICATIONS:

COOPERATIVE _____ RESISTANT _____

DIET AND ORAL HABITS:

MEALTIMES:

TYPICAL _____ ATYPICAL _____ SPECIAL DIET _____

DESCRIBE _____

WATER: _____ **FREQUENCY:** _____

OTHER DRINKS: _____ **FREQUENCY:** _____

SNACKS: _____ **FREQUENCY:** _____

FRUITS: _____ **FREQUENCY:** _____

VEGETABLES: _____ **FREQUENCY:** _____

Does your child suck a thumb, finger, pacifier or other object? _____

BEHAVIOR AND COMMUNICATION:

To whom is your child most responsive? _____

Describe interactions with peers or adults outside of home and school: _____

Does he/she become physically or verbally abusive when angry or frustrated? Please explain. _____

Does your child communicate best VERBALLY _____ or NON-VERBALLY _____?

If NON-VERBAL, which system applies:

___ Mayer Johnson Symbols

___ Sign Language

___ Picture Exchange Communication System (PECS)

___ Sentence Board or Gestures

WHAT USEFUL PHRASES, WORDS or SYMBOLS WILL WORK BEST WITH YOUR CHILD?

EDUCATIONAL SUPPORT SYSTEM:

Does your child have an Individualized Educational Program (IEP)? _____

If so, have oral hygiene skills been incorporated into the IEP? _____

What school does your child attend? _____

Which types of therapy does he/she have currently?

___ Occupational (sensory integration)

___ Speech

___ Physical

___ Applied Behavior Analysis (ABA)

___ Other (describe) _____

SENSITIVITIES

Is your child sensitive to any of the following? (Circle those that apply and add any we missed.)

Smell: *office, perfume, cologne*

Sounds: *music, drill, phones, voices, clock*

Sight: *lights, mirrors, shiny tools*

Positions: *chair height and tilt, being "still", laying flat*

Touch/Temp: *gloves, air, gauze, water, suction*

Texture: *toothpaste, gauze, cotton, metal*

Taste: *gloves, toothpaste, fluoride*

How does your child indicate sensitivity? _____

COMFORT ZONE

Does your child like to be wrapped in a heavy blanket? _____

Is your child soothed by:

watching DVD's

listening to music on an IPOD

What **REWARDS** (*foods, toys, games, activities, etc.*) do you use to encourage good behavior?

Which do you think would work best for your child's dental visit? _____

What goals do you have for your child's dental experience? _____

Do you have any other suggestions for us that might make your child's visit more comfortable?
