

Pediatric Dental Questionnaire

Your child's name: _____ Date of Birth _____

Special Needs Diagnosis _____ Developmental Age: _____

Please describe any dental visits, behavior, coping: _____

Your child requires:

A check-up _____	A dental cleaning _____
Cavities filled _____	Sealants _____

Your child's behavior might be:

Age applicable _____	Playful _____
Unresponsive _____	Wiggly _____
Short Attention _____	Combative _____
Unfocused _____	Aggressive _____

The management approach I prefer for my child would be:

Short, multiple appts. _____	Sedation _____
No restraint _____	Nitrous Oxide _____
I.V. Sedation to complete treatment in one appointment _____	

It would be best for my child if I would remain in the exam room _____
or the Waiting Room _____ during my child's dental visit.

Please explain: _____

Connecting with your Child

Does your child best communicate non-verbal? _____ or verbal? _____

Might your child be verbally or physically abusive if frustrated/angry?

Please explain: _____

In a setting out of the home/school describe your child's cooperation with other children/adults? _____

Connecting with your child (continued)

Could your child be more perceptive/sensitive to a stimulus in a dental setting? And how could your child express these stimuli? Please explain.

Sights: _____

Smells: _____

Sounds: _____

Positions: _____

Tastes: _____

Textures: _____

Touch/Temperatures _____

What would work best for this dental check-up? _____

Tell us about your child's best comfort, soothed by music, ipods, ipads, etc.

Which rewards could you use to boost your child's good conduct? _____

Which goals do you have for the dental visit? _____

What other suggestions might you have for us to make your child's appointment more cozy and pleasant? _____

Please print out this Questionnaire and bring it to your child's appointment.