

Name: _____

Date of Birth : _____

Note: The following questionnaire is *optional* and relates to treatment modifications specific to your child. Thanks!

Communication & Behavior

Is your child able to communicate verbally? Yes No

Are there certain cues that might help the dental team?

Are there any useful phrases or words that work best with your child?

Does your child use non-verbal communication? Yes No

Does your child use any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Picture Exchange
Communication System (PECS) | <input type="checkbox"/> American Sign Language |
| <input type="checkbox"/> Mayer Johnson Symbols | <input type="checkbox"/> Sentence Boards/Gestures |
| <input type="checkbox"/> Talker/iPad/Assistive Device | |

Will you be providing an alternate communication system? Yes No

Behaviors/Emotions

Please list any specific behavioral challenges that you would like the dental team to be aware of:

Please list specific non-food motivators your child responds well to (i.e. stickers, stuffed animals, coloring pages, etc.)

Please feel free to bring objects that are comforting/ motivating for your child to their visit.

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Sensory Details

Please list any specific sounds that your child is sensitive to:

Does your child prefer the quiet? Yes No

Is your child more comfortable in a dimly lit room? Yes No

Is your child sensitive to motion and moving (i.e. the dental chair moving up and down or to a reclining position?) Yes No

Does your child have any specific oral sensitivities? (gagging, gum sensitivities, etc.) Yes No

Do certain tastes bother your child? Yes No

If yes, please list below:

Please provide us with any additional information that may help us in having a successful dental experience!

Treatment

Modifications/Accommodations

*Ask for more details! *coming soon!*

Touch and Feel Box

Private Room *

Token Board Reinforcement

3 Month Schedule VS. 6 Month Schedule

Weighted Blanket

Noise Cancelling Headphones

Papoose Board *

Stationary Exam Chair

Visual Timer