

**PRE-APPOINTMENT INFORMATION FOR CHILDREN WITH SPECIAL NEEDS
PROGRAM QUESTIONNAIRE FOR PATIENT/GUARDIAN**

Date: _____

Childs Name: _____ Age: _____

Siblings Order: _____

Diagnosis: _____

When was your child diagnosis? _____

What special needs characteristics do you notice most in your child?

Medication: _____

Previous Dental Visits: _____

My child needs: (check whichever apply)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> 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's cooperation will 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 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"/> operating room to finish treatment in one visit |

Agree or Disagree: (*circle one*)

It is best if I wait in the waiting room because the doctor knows best how to deal with my child's behavior best in the dental environment.

Agree

Disagree

It is best if I wait in the waiting room because the being at the dentist makes me anxious and that wont help my child.

Agree

Disagree

It is best if I stay with my child because my child needs me to be there.

Agree

Disagree

It is best if I stay with my child because I can help the doctor and staff.

Agree

Disagree

It is best if I stay with my child because I need to be there for my own well-being.

Agree

Disagree

Describe the child's support system at school:

Is there a personalized program in place? Yes No

Is there an educational assistant? Yes No

Is there an occupational therapist? Yes No

Is there a Physical therapist? Yes No

What is the placement type? *Circle one*

Class integration

Special Education

What other supports or services have the family/child accessed?

Socialization:

How does your child interact/react with peers or adult outside of home or school?

Is your child responsive to instructions? Yes No

If yes, please give examples.

To whom is your child most responsive?

Can your child make eye contact? Yes No

If yes, for how long?

Does your child have trouble separating at school, with doctors, or for haircuts? Yes No

Reinforcers: (i.e.: favorite toys, items, or activities that are used as rewards or to encourage positive behavior.)

What is used at home/school?

Sensitivities:

Is your child sensitive to any of the following – circle those that apply and add any if we have missed them.

Smell: *office, perfume, cologne*

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

Sight: *lights, overhead arm, mirrors, shiny tools*

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

Proximity: *people, water, light, x-ray machine*

Touch/Temp: *gloves, air, gauze, water, suction, room & water temp*

Texture: *toothpaste, gauze, cotton, metal*

Taste: *gloves, toothpaste, fluoride*

How does your child indicate sensitivity?

How have they responded to these sensitivities in the past?

Your Goals/Expectations: *(to be completed by office staff)*

What are the goals for your child in our office?

What are our expectations for your child?

What would we consider success?