

Getting to Know Your Child

Patient Name: _____ Date: _____

If you need more room to elaborate on your answer, please use reverse side.

1. Has your child been diagnosed with Autism? **Y** or **N**. Does your child exhibit any atypical behaviors?

2. How do you communicate most effectively with your child? _____

3. How does your child communicate with others? _____

4. How does your child respond in social environments? _____

5. How does your child do at other appointments such as the pediatrician or getting a haircut?

6. In the past, or currently does your child see a specialist/behaviorist? **Y** or **N**
Name _____ Telephone # _____
7. Has your child seen the dentist before? **Y** or **N** If yes, please briefly describe how the visit went.
Were you able to complete a cleaning or x-rays? _____

8. Do you feel your child would do well with a music option playing? **Y** or **N**
9. How do you praise your child, such as rewards with stickers, candies, books, etc.?

10. How successful is oral hygiene at home?
 - a. Parent or caregiver are able to brush/floss daily
 - b. Child brushes and flosses on their own
 - c. Child is uncooperative for tooth brushing
 - d. Caregiver is unable to effectively brush/floss
11. Does your child have any of the following (please explain):
 - a. Specific diet _____
 - b. Allergies _____
 - c. Difficulty with certain textures or taste _____
 - d. Gag reflex/Acid reflux _____
 - e. Tube Fed _____
12. Please list all medications your child is taking: _____

13. Do you have any concerns about your child's oral health? _____

14. What are your expectations for today's visit? _____

Any suggestions you can offer our staff to help create a successful visit for your child are welcome. Additional information can be written on the back of this paper. We look forward to meeting you and your child!