Additional questionnaire for Autistic, PDD patients

MEDICAL INFORMATION

Patient Name:___________________________ Nickname:____________ Parent/Guardian_________________________
Phone Number (____)_____-____________ Parent/Guardian_________________________
Describe the nature of your child's disability: ____
Are they currently taking any medications? **YES NO** List of Medications: ____
Has your child ever had seizures? **YES NO** Date of last seizure: _____/_____/________
Describe type of seizure____
Does your child have any allergies? **YES NO** List of Allergies: ____
Does child wear Hearing Aids? **YES NO**
Does child have any physical challenges that the dental team should be aware of? **YES NO**
What are they? ____

COMMUNICATION AND BEHAVIOR

Is your child able to communicate verbally? **YES NO**
Are there any 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**
Please check the following that your child uses:

- □I-pad
- □Mayer Johnson Symbols
- □ Sign Language
- □Picture exchange Communication System (PECS)
- □Sentence Board or Gestures

Are there any symbols/signs that we can have available to assist with communication? ___________________________
BEHAVIOR/EMOTIONS
Are there specific behavioral challenges that you would like the dental team to be aware of?_______________________

SENSORY ISSUES

Are there any sounds that your child is sensitive to? **YES NO** ____
Does your child prefer quiet? **YES NO** Is you child comfortable in a dimly lit room? **YES NO**
Is your child sensitive to motion and moving? **YES NO** (i.e. dental chair moving or reclining)
Does your child have any specific oral sensitivity? **YES NO** (i.e. gagging, gum sensitivities)
Do certain tastes bother your child? **YES NO**
Is your child more comfortable in a clutter-free environment? **YES NO**
Please provide us with any additional information that may help us to prepare for a successful dental experience:
____
____

ORAL CARE

Has your child visited the dentist before? **YES NO** How was it? ____
Does your child use a powered toothbrush? **YES NO** Manual toothbrush? **YES NO**
Does your child floss? **YES NO**
Does your child brush independently? **YES NO** who helps your child? ____
What are your dental health goals? ____
How often does your child snack during the day? **YES NO** What types of snacks? ________________________________