Pre-Visit Parent Questionnaire for Patients with ASD

Date______________

Child's First and Last Name____ Date of Birth_____________

Address____ Phone #______________________

Medical Diagnosis____

Medications____

Allergies____

You may include a separate written list of medications and allergies if there are a large number of items

Who referred you to us? ____

Your Child's Primary Care Doctor____

PLEASE CHECK All THE RESPONSES THAT ARE APPROPRIATE FOR YOUR CHILD

Your child's educational support system

□ Has an educational assistant or behavioral therapist

□ Has a personalized school program in place (IEP)

Classroom type Integrated class Special Education

□ Other ____

How would you describe your child's ASD?

Mild Moderate Severe Don't Know

How does your child communicate?

Language Understanding	Limited	Some	Most
Speech	Non-verbal	Limited verbal	Highly Verbal
Reading	Non-reader	Some reading	Fluent reader
Complies with simple instructions	Rarely	Sometimes	Usually

What tools does your child use to communicate?

Social Stories Visual Schedules iPad Pictures

Other____

Which activities can your child do on their own?

Toileting Toothbrushing Bathing Hair brushing Dressing

What are your child's strengths?

What are your child's interests?

Is your child sensitive to any of the following?

Loud Noises Bright Lights Unfamiliar Smells Unfamiliar Tastes

Other____

What are the best rewards for your child?

iPad/tablet time Prize/trinket from dentist Special food/meal Special outing

Other____

What kind of treatment would you like our team to provide?

Routine Exam Cleaning Filling/Crown Extractions A lot of work Orthodontics

What would be your preferred way to accomplish your child's care?

☐ Desensitization/Behavioral Approach

☐ Sedation/General Anesthesia

☐ Restraint/Protective stabilization

☐ Other, Describe

How did your child's last dental visit go? **What could have made it easier?**

Is there anything else that you would like us to know about your child?

For office use only			
Type of exam		RC	NP
Room	QR	Semi	Open
Time (min)	30	40	60

Thank you for completing this form. The information will be used to help your child with dental treatment

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