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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