Dental Office Pre-Visit Questionnaire for Parents/Caregivers of Persons with Special Health Care Needs

This questionnaire is intended to capture information about pediatric patients, but it can also be used or adapted for adult patients with special health care needs.

The purpose of this form is to share important details about your child's medical history, oral care routine, diet preferences, communication abilities and sensory sensitivities with the dental team. This information will help the dental team prepare to make the dental visit as comfortable as possible for your child. Please return the completed form to the dental office before your child's scheduled appointment. When completed, this form will contain your child's personal health information. Since regular email is not secure, do not email the completed forms back to the dental office. Your dental office may have a secure portal to submit personal health information and completed forms. Be sure to ask about it and use the portal to conveniently and securely submit the information. Alternatively, please drop the completed forms off at the dental office or send by mail.

Reminder: It's always important to provide informed consent. Parents and caregivers are encouraged to be present at the appointment to give informed consent for care to be provided. Should another individual, such as a guardian or sibling, accompany your child/the person you are caring for at the appointment, then consent for treatment should be arranged in advance of the appointment. Written consent is preferred; however, it can also be done verbally through direct communication with the oral health care provider. The patient's file will be documented with this important information.

Patient Name: _____

DIAGNOSIS AND MEDICATIONS:

1. Describe the nature of your child's diagnosis/special needs: _____

2. Please list any medications, vitamins, and herbal or mineral supplements your child is taking: _____

ORAL CARE AT HOME AND IN THE DENTAL OFFICE:

3. Has your child visited the dentist before? ☐ No ☐ Yes (If yes, please list date) _____

4. Please describe your child's at-home dental routine: _____

5. Does your child use an ☐ electronic or ☐ manual toothbrush?

6. Does your child floss? ☐ No ☐ Yes

7. Does your child need assistance when brushing their teeth? ☐ No ☐ Yes

8. Does your child tolerate having X-rays taken? ☐ No ☐ Yes ☐ Unknown (If yes, please describe what has previously worked well to improve the experience for your child.) _____

9. If your child uses a wheelchair, please check the box that best applies:

☐ My child can safely transfer themselves to another space, such as a dental chair.
☐ My child requires assistance with a wheelchair transfer.
☐ Unknown

10. Sometimes individuals are required to wear masks in public (i.e. during a pandemic, due to respiratory illness, etc.). Can your child comfortably wear a mask, if necessary? ☐ Yes ☐ No ☐ Unknown

ORAL CARE GOALS:

11. What are your expectations for your child in our dental office? _____

_____

_____

12. What are some oral health goals you would like to set for your child? _____

_____

_____

_____

13. What would success look like for you? _____

_____

_____

DIET:

14. Select all that apply. How often does your child eat during the day: ☐ 3 meals a day; ☐ snacks in between meals; and/or ☐ eats only when hungry.

15. Does your child drink soft drinks? ☐ No ☐ Yes

16. Does your child drink fruit juice? ☐ No ☐ Yes

17. What are your child's food preferences and dislikes? _____

_____

_____

SUPPORT SYSTEM AT SCHOOL:

18. Is there an educational assistant? ☐ No ☐ Yes

19. Is there a personalized program in place? ☐ No ☐ Yes

If yes, what is the name of the program and describe it. _____

_____

20. What is the placement type? ☐ Class integration ☐ Special Education ☐ Other _____

_____

SOCIALIZATION AND REINFORCEMENTS:

21. What does your child do to self-regulate? _____

22. Describe how your child interacts/reacts with peers or adults outside of the home and school: _____

23. List other supports or services your child (or family) has accessed: _____

24. Is your child responsive to instructions? ☐ No ☐ Yes If yes, provide an example: _____

25. To whom is your child most responsive: _____

26. Can your child make eye contact? ☐ No ☐ Yes If yes, for how long, approximately? _____

27. Is it difficult for your child to separate from you at school, with doctors, or for haircuts? ☐ No ☐ Yes

28. Does your child respond differently to individuals who identify as male or female?

☐ No ☐ Yes If yes, which gender produces a more positive response? _____

29. Do you use toys, activities, or treats to reward or encourage positive behaviour? ☐ No ☐ Yes If yes, please describe what is used at home and/or at school: _____

SENSITIVITIES:

30. If your child is sensitive to any of the following **OR** has sensory preferences that can improve his/her/their experience, please check all boxes that apply, circle/highlight specific aspects, and provide additional information in the space provided:

Example:

☑ **Taste:** Gloves, toothpaste, fluoride, specific flavours, other: **Prefers bubblegum and fruit flavours. Does not like grainy textures.**

☐ **Smell:** office setting, perfume, cologne or other: _____

☐ **Sounds:** Music, television background noise, drill, phones, voices, clock, other: _____

☐ **Sight:** Dim lights, bright lights, pulsating lights, lighting colour, overhead arm from the light of the chair, mirrors, shiny tools, other: _____

☐ **Positions:** Chair height or tilt, being "still," laying flat, other: _____

☐ **Proximity:** People, water, light, X-ray machine, other: _____

☐ **Touch:** Gloves, air, gauze, water, suction, room and water temperature, tooth brushing, weighted blanket, other:_____

_____

☐ **Taste:** Gloves, toothpaste, fluoride, specific flavours, other:_____

31. How does your child indicate/communicate his/her/their sensitivity(ies)?_____

_____

_____

32. How have you responded to your child's sensitivity(ies)? And how has this/these methods worked?_____

_____

_____

COMMUNICATION AND BEHAVIOUR:

33. Is your child able to communicate verbally? ☐ No ☐ Yes

34. Are there certain visual or verbal cues that might help the dental team? If yes, please describe:_____

_____

_____

35. Are there any useful phrases or words that work best with your child? Please describe:_____

_____

_____

36. Does your child use non-verbal communication? ☐ No ☐ Yes If yes, please explain how:_____

_____

_____

37. Will you be bringing a communication system with you? ☐ No ☐ Yes If yes, please explain:_____

_____

_____

38. Will you be bringing visual supports to help your child during the visit? If yes, please explain:_____

_____

39. Are there any others supports that we can have available to assist with communication? If yes, please explain:_____

_____

_____

OTHER:

40. What else can our dental office be aware of to help make dental visits as comfortable and possible for everyone involved? Please describe:_____

_____

_____

_____

_____