

# 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?

<i>Language Understanding</i>	Limited	Some	Most
<i>Speech</i>	Non-verbal	Limited verbal	Highly Verbal
<i>Reading</i>	Non-reader	Some reading	Fluent reader
<i>Complies with simple instructions</i>	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**