Supplemental Health History Questionnaire

Patient Name: ____ Date: _____________________

On your health history you have identified your child with ____________________________. Would you please help us understand more about this condition and how it might affect your child in a dental / orthodontic setting?

1) Please tell us about the condition your child has and how it affects his/her behavior.

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2) Please describe any significant fears or anxieties that your child may experience during visits to health care professionals *(including dental).*

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3) Has the anxiety or fear prevented any necessary treatment? Please describe.

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4) Are there any strategies that help your child feel comfortable in a new situation such as orthodontic treatment? *(Examples: show and tell, humor, going very slowly; modeling with parent or sibling, use of sound machine, and or weighted blanket, use of iPad, others examples)*

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5) Are there <u>physical disabilities</u> that need to be taken into consideration? *(Example: difficulty with fine motor skills)*

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6) Are there <u>learning disabilities</u> that need to be taken into consideration?
(Examples: auditory processing difficulties, sensory integration dysfunction, speech and language difficulties)

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7) Is there any additional information that might help us provide a positive office experience for your child?

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