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Social and Behavioral History

Patient Name:

_____

Parent /Guardian/Caregiver:

_____

Medical Information:

Describe the nature of your child's health and social history:

_____

_____

_____

Has your child ever had seizures? Yes No

If Yes, date and type of last seizure:

_____

Is your child on any special diet? Yes No

What type of foods does your child like to eat on a regular basis?

_____

Does your child have any physical challenges that the dental team should be aware of? Example: in a wheelchair, delayed fine motor skills, etc.:

_____

_____

_____

Oral Care and History:

Has your child visited the dentist before? Yes No
If yes, please describe the experience for both you and your child.

_____

_____

_____

Please describe your child's at-home care:

Brushing frequency?_____

Aided or independent?_____

Manual or electric toothbrush?_____

What kind of toothpaste do you use?

_____

Flossing Frequency?_____

Aided or Not?_____

Does your child have any issues spitting? Yes No

Fluoride/ varnish ok to use on your child? Yes No

Who assists your child during their home care?

_____

Where is home care performed and in what position? Example: in bathroom and standing or in bedroom lying on the bed:

_____

Are you having any challenges with brushing and flossing at home? Yes No
If yes, please describe:

_____

Communication and Behavior:

Is your child able to communicate verbally?
Yes No

If yes, is communication level age appropriate?
Yes No
If no, what is their developmental/communication age level?
_____

Are there certain cues that might help the dental team? Example: Hands quiet, mouth quiet, etc.:
_____

Does your child use non-verbal communication?
Yes No

If yes, please describe:
_____
_____

Are there any specific behavioral challenges that you would like the dental team to be aware of? Example: yelling/screaming, self-injury, aggressive toward others, meltdowns, inability to sit still, etc.:
_____
_____

What rewards are used as reinforces for good behavior for your child? Example: Food, toys, games, movies, other sensory tools, etc.:
_____

Are there any sounds that your child is sensitive to?
_____

Does your child prefer quiet? Yes No

Is your child sensitive to motion and moving? Example: the dental chair moving up and down or laying back? Yes No

Does your child have any specific oral issues? Example: gagging, gum sensitivities, pica (eating nonfood objects), pouching of food, chewing or sucking on hands/fingers etc.:
_____
_____

Do certain tastes or flavors bother your child?
Yes No
If yes, please list:
_____

Expectations and Concerns:

What are your expectations for your child's visit?
_____

Please list any fears or concerns you may have about bringing your child to the dentist:
_____
_____
_____
_____

Are there any other issues our team should be aware of or would help us better care for your child?
_____
_____
_____
_____

When necessary, we utilize different forms of behavior modification techniques to ensure the comfort and safety of your child. Please number in the order of your preference:

_____Desensitization

_____Protective medical stabilization

_____ Conscious sedation

_____ General Anesthesia