Raleigh Pediatric Dentistry
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QUESTIONNAIRE FOR PARENTS OF PATIENTS WITH AUTISM

Child's name_____ **Date**_____

In order for us to better serve your child, we would appreciate your cooperation in completing this questionnaire. There may be some duplicate questions that coincide with our general health history form; if the answer is extensive, please make a note that refers our office to the correct form.

1) When was your child first diagnosed?

2) If your child sees a specialist(s), please list their names and phone numbers:
Doctor's Name *Specialty Field* *Phone #*

3) Birthday: _____What is your child's exact age in years and months? _____years _____months

4) What is your child's approximate developmental age? _____years

5) At what level does your child communicate verbally?
____*normally (no delay)* ____*mild delay* ____*moderate delay* ____*does not speak*

6) Was your child toilet trained by age 4 years? ____*NO* ____*YES*

7) Is your child able to sit still for a haircut? ____*NO* ____*YES*

8) Does your child have specific sensitivities to certain things (ie light, sounds)? Please list.

9) Is your child receiving medication and, if so, which medications is your child currently taking, and the dosage? ____*No medicines* ____*Yes (please list info)*

10) Is this your child's first visit to a dentist? ____*NO* ____*YES*

11) Has your child had any negative dental experiences and, if so, please describe? _____*NO* _____*YES*

13) Anything else you would like us to know?