Client Pre Assessment for Dental Visit Date:

Name:

Age:

Designations:

Now that you child has participated in the home based program, to assist in making the dental office the most positive experience, please provide feedback on the following:

Can your child sit quietly and wait for 10 minutes? □ yes □ no if not how long could they wait? _____

Does your child feel comfortable lying down and having you look in their mouth? □ yes □ no

Is you child able to keep hands crossed on their tummies? □ yes □ no

Is your child comfortable with seeing you with a mask on? □ yes □ no □ do not wear a mask

Is your child comfortable with light shining in their mouth? □ yes □ no

Is your child comfortable with gloves touching the cheek and in their mouth? □ yes □ no

Is your child comfortable with having the bib placed? □ yes □ no

Is your child comfortable with cotton is their mouth? Holding the tongue? □ yes □ no

Is your child comfortable with counting teeth? □ yes □ no

Will your child open their mouth when asked ? □ yes □ no what works to get the mouth open?

_____-_

Does your child know how to use the suction straw "kiss the straw" □ yes □ no

Is your child comfortable with the plastic mouth mirror in their mouth? □ yes □ no

Is your child comfortable with any type of toothpaste? □ yes □ no Specific type? _____

Is your child comfortable water in their mouth? □ yes □ no

Does you child have any trouble with swallowing? □ yes □ no or gagging? □ yes □ no

Are their any noises that increase anxiety in your child? □ yes □ no describe _____

Does music excite or calm you child? □ Excite □ calm what type calms _____

Does you child have a "stop" signal? □ yes □ no describe _____