Client Pre Assessment Date:

Name:

Age:

Designations/Medical Diagnosis

Past dental history: □ has seen a dentist □ has seen a dental specialist (pedodontist) □ have not seen a dentist?

If has seen a dentist was this: □ with no medications □ with oral sedation □ with IV sedation □ in the OR

How was this experience for your child?_____

How was this experience for you, the care giver? _____

How do you and your child communicate: □ verbal □ non verbal □ Lip reads □ hearing aids □ other

_____

Are you aware of any triggers that lead to stress in your child?

Sensory: □ light □ noise □ touch □ colours □ tastes □ smells □ other _____

When approaching your child to brush their teeth does you child:

□ kick □ bite □ scream □ cry □ hit □ flail □ rock

Does this happen □ always □frequently □moderately □ occasionally

What strategies work best to calm your child?

_____

When your child is stressed, is there a “stop or pause” sign that is used to help the child? □ no □ yes describe:

_____

Who provides currently provides oral care? □ mother □ father □ care giver

When is the best time of day to provide oral care? □ morning □ afternoon □ evening

What challenges do you face? _____

Additional information: