

FIRST IMPRESSIONS FAMILY DENTISTRY
SPECIAL NEEDS QUESTIONNAIRE

To better understand your child, we have compiled a comprehensive questionnaire to help determine dental treatment needs and assess whether or not sedation would be useful to complete treatment. Please provide as much information as possible and provide us anything else that may be beneficial to successfully accomplish treatment.

- 1. Please list or describe special need/disability for your child. Date of diagnosis? Name and contact information of all pertinent physicians that we may consult with?**
- 2. List all medications your child is currently taking including dosages and how long your child has been taking them.**
- 3. List all supplements and any OTC medications your child takes on a regular basis.**
- 4. List any allergies your child has along with the reaction they have.**
- 5. List, if any, applicable therapies your child receives (occupation, speech, ABA, etc.)**
- 6. Is your child on any special diet or have any specific restrictions?**



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- 7. List any previous dental treatment your child has received along with dates and types of treatment. Do they have any siblings who have received previous dental treatment and how was their experience?**

- 8. Does your child have any sensory issues pertinent to treatment?
E.g. Sounds, touch, taste, pressure, postural?**

- 9. How does your child communicate (if nonverbal)? How do they communicate anxiety, pain, discomfort?**

- 10. Does your child have any specific interests (favorite shows, movies, toys)?**

- 11. Describe your child's oral hygiene routine and how they respond to oral hygiene aids (i.e. toothbrush, floss, toothpaste)**

- 12. Does your child have better tolerance for morning or afternoon appointments?**

- 13. Anything else that would benefit us knowing to better provide treatment for your child?**