Holland Bloorview
Kids Rehabilitation Hospital

Client Name _____
Health Record Number _____
Date of Birth _____

Dental Services
Learning about your child in preparation for their dental visit

Does your child have: ☐ Behavioural issues ☐ Anxiety ☐ Other _____

Please tell us about your child's previous experiences in health care settings

Has your child received dental services? ☐ Yes ☐ No
If yes, where? Comments:_____
_____
Has your child received sedation prior to dental services? ☐ Yes ☐ No
If yes, were there any issues? _____
_____

Please tell us about your child's behaviour

How does your child react to new environments? _____
_____
_____
How does your child react to other children and adults? _____
_____
Is your child sensitive to the following? ☐ Touch ☐ Noise ☐ Smell ☐ Taste ☐ Other _____
What is the best way to approach your child?
_____
_____
Does your child demonstrate physical aggression? ☐ Yes ☐ No
If yes, is he/she physically aggressive towards ☐ Self? ☐ Others?
If yes, how and when does he/she act when aggressive? _____
_____
What interventions work best when your child is overstimulated or agitated?
_____
_____
_____

Please tell us about your child's communication skills

What is the best way to communicate with your child?

- ☐ Verbal
- ☐ Communication device, please specify: _____
- ☐ Sign language
- ☐ Other _____

How does your child communicate he/she is in pain? _____

_____

What are some ways we can help ensure your child's experience is positive?

_____

_____

_____ _____

Name of parent/guardian completing this form Date

Planning for future appointments

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