



HAMILTON COUNTY
PEDIATRIC DENTISTRY

Communication and Sensory Questionnaire

Patient Name: _____

1. What is the biggest challenge you anticipate with the first dental visit?
2. What is your primary goal for the first dental visit?
3. Is your child able to communicate verbally?
4. Does your child use any form of non-verbal communication (sign, tablet, etc)?
5. Does your child work with a therapist?
6. Will you bring a therapist to the appointment?
7. How does your child respond to loud sounds?
8. Would your child benefit from watching a TV/movie during treatment?
9. Does your child prefer bright or dim lights?
10. Is your child sensitive to motion?
11. Is your child sensitive to certain tastes/textures?
12. Does your child have any oral sensitivities (oral aversion, gag reflex, etc)?
13. How do you calm your child when he/she is upset?
14. Are there any words or phrases you use to guide your child's behavior?
15. Would your child benefit from a step-by-step checklist of the appointment steps?
16. Would your child benefit from a visual photo book of the appointment steps?
17. Any additional information that would help us customize your child's first visit?