GKG Orthodontics Supplemental Orthodontic History Questionnaire

Patient Name: _____ Date: _____

On your health history you have identified your child with _____. Would you please help us understand more about this condition and how it might affect your child in a dental / orthodontic setting?

1. Could you tell us about the condition your child has and how it affects his/her behavior.

_____

_____

2. Please describe any significant fears or anxieties that your child may experience during visits to health care professionals *(including dental).*

_____

_____

3. Has the anxiety or fear prevented any necessary treatment? Please describe.

_____

_____

4. Are there any strategies that help your child open up to new experiences such as a visit to a new doctor?
(Examples: show and tell, humor, going very slowly; modeling with parent or other sibling, others examples)

_____

_____

5. Are there physical disabilities that need to be taken into consideration? *(Example: difficulty with fine motor skills)*

_____

_____

6. Are there learning disabilities that need to be taken into consideration?
(Examples: auditory processing difficulties, sensory integration dysfunction, speech and language difficulties)

_____

_____

7. Is there any additional information that might help us provide a positive office experience for your child?

_____

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