Patient Name:____ Date of Birth:______________

If your child has an **Autism Spectrum Disorder**, please help us make this the best experience possible for him/her by answering the following questions:

How would you describe your child's ASD: Mild Moderate Severe Don't Know

How does your child communicate?

• *Language understanding*	Limited	Some	Most
• *Speech*	Non-Verbal	Limited Verbal	Highly Verbal
• *Complies with simple instructions*	Rarely	Sometimes	Usually

What activities can your child complete on their own:

Restroom Bathing Dressing Hair brushing Toothbrushing

Is your child sensitive to any of the following:

Loud Noises Bright Lights Unfamiliar smells Unfamiliar Tastes

What reward system works best for your child? ____

____

Has your child had any negative experiences with a doctor or dentist: No Yes

If yes, please explain: ____

What can we do to make this visit easier for your child? ____

____

Does your child express any concerns about aspects of his/her teeth or mouth? No Yes

If yes, please explain: ____

Is there anything else you would like us to know about your child? ________________________________

____

Thank you!!