

ID#: _____

Date: _____

Thank you for agreeing to participate! The information we gather will help us better treat your child and others. The following survey contains questions about your child's medical history, behavior, verbal skills, and dental history. There are also questions about your preferences regarding dental treatment. There are 17 total questions. Please answer them as best you are able.

1. Child's Date of Birth: _____/_____/_____
Month Day Year

2. Child's Gender

☐ Female

☐ Male

3. Child's Race (check all that apply)

☐ White/Caucasian

☐ African American

☐ Hispanic

☐ Native American

☐ Asian

☐ Other, please specify _____

4. Please List all languages spoken at home

5. What type of Autism Spectrum Disorder does your child have?

☐ Autism/Autistic Disorder

☐ Asperger's

☐ Pervasive Developmental Disorder-Not Otherwise specified (PDD-NOS)

☐ Don't Know

☐ Other, please specify: _____

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6. Would you describe your child's ASD as:

- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Don't Know

7. Is your child receiving any of the following? Please check all that apply.

- ☐ Behavioral therapies such as: Applied Behavior Analysis, Developmental, Individual Relationship based Approach, or any others?
- ☐ Physical therapy
- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Complementary Alternative Medicine such as: special diets, supplements, vitamins, acupuncture, other eastern medicines, or chelation therapy

The following 3 questions are about your child's verbal and reading skills

8. How would you describe your child's reading level?

- ☐ Not Applicable (<5 yrs old)
- ☐ Does not read
- ☐ Some skills but not fluent
- ☐ Fluent reader
- ☐ Don't know

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9. What is your child 's communication ability?

- ☐ Non-verbal
- ☐ Limited Verbal
- ☐ Verbal
- ☐ Mimicking (Echolalia)

10. How would you describe your child 's understanding of language?

- ☐ Does not understand
- ☐ A little or some understanding
- ☐ Understands most or all language
- ☐ Other (please describe): _____

The following 4 questions are about your child's behavior

11. How would you describe your child 's level of challenging behaviors?

- ☐ Typically engages in minimally challenging behaviors
- ☐ Typically engages in disruptive behaviors
- ☐ Typically engages in dangerous behaviors

12. How would you describe the typical frequency of your child's challenging behaviors?

- ☐ <1 per day ☐ 1-2 per day ☐ 3+ times per day ☐ never

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13. Please rate your child's ability to take part in the following

	Not Able	Rarely Able	Sometimes Able	Often Able	Able all the Time
Engage with you in shared activity (Joint attention)	☐	☐	☐	☐	☐
Read Stories with you (caregiver/parent)	☐	☐	☐	☐	☐

14. Does Your Child:

	Always	Most of the time	Sometimes	Not Much	Never
Follow one-step directions	☐	☐	☐	☐	☐
Use sign language	☐	☐	☐	☐	☐
Use PECS (Pictures)	☐	☐	☐	☐	☐
Communicate using written words (Computer/Pen/Paper)	☐	☐	☐	☐	☐

The following 3 questions are about your child's dental history**15. Has your child ever seen a dentist?**☐ Yes☐ No → Skip to question # 18

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16. Has your child ever had any of the following during a dental visit?

a. Papoose board (immobilization wrap/restraint)

☐ Yes ☐ No ☐ Don't Know

b. Sedation (calming medication)

☐ Yes ☐ No ☐ Don't Know

c. General anesthesia (loss of consciousness during surgery)

☐ Yes ☐ No ☐ Don't Know

**17. Which of the following would be your preferred treatment choice?
(please rank your preferences, 1 being your first choice)**

___ Gradual desensitization and behavioral modification approach

___ Sedation (calming medication)

___ Restraint / protective stabilization

___ General Anesthesia/Operating Room (loss of consciousness as during surgery)

___ Other, describe: _____