American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

Supplemental Orthodontic History Questionnaire

Date _____

Patient's Name _____

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 had and how it affects 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, other examples)*? _____
5. Are there physical disabilities that need to be taken into consideration? (Examples: Difficulty with fine motor skills) _____
6. How does your child deal with physical discomfort? _____
7. Are there learning disabilities that need to be taken into consideration? *(Examples: Auditory processing difficulties, sensory integration dysfunction, speech and language difficulties)* _____
8. Any additional information that might help us provide a positive office experience for your child? _____