

DR. PHILIP M. ROBITAILLE

PATIENT INFORMATION (Please Print)

Date: _____

PERSONAL INFORMATION:

Name: _____

Address: _____

City _____ State _____ Zip Code _____

Phone:
(home) _____ (work) _____

Email
Address: _____

Date of Birth: ____ / ____ / ____ Age: ____ Height: _____
Weight: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address:(if different from above)

Phone: home- _____

work- _____

Current Physician: _____

Phone: _____

MEDICAL INFORMATION:

Describe the nature of your disability:

Are you currently taking any medications? YES NO

If yes, what medications: _____

Describe side effects of current medications: _____

Have you ever had SEIZURES? YES NO

If YES, date of last seizure _____

Describe the type of seizure _____

Do you have any ALLERGIES? YES NO

If yes, please list _____

Do you have any FOOD SENSITIVITIES OR AVERSIONS? YES NO

If yes, please list _____

Do you have any BLADDER or BOWEL ADAPTATIONS? YES NO

Please list any adaptations: _____

Are there any precautions we should be aware of regarding bladder/bowel control?:

DENTAL EXPERIENCE:

Have you had any dental experiences? YES NO If yes, please describe _____.

Do you have a dental experience at home on a daily basis? YES NO
If yes, please describe _____.

How would you describe your tolerance for dental experiences? Good Fair
Poor

Do you use a powered toothbrush or a manual toothbrush? _____

What are your dental health goals? _____

ORAL HABITS

How often are you snacking during the day? _____

Is food used as a reward during therapy?: _____

If yes, what types of food do you prefer?: _____

Do you need to chew for sensory stimulation? _____

If yes, how often per day?: _____

If yes, what materials do you chew on?: _____

Do you have a tendency to put non-edible items in your mouth?

If yes, please describe?: _____

PHYSICAL FUNCTIONING

Are you currently working or attending school? _____

If yes, how long is your average work or school day?: _____

Do you have difficulty breathing? _____

Do you have normal range of motion in the following?

Right arm: YES NO Left arm: YES NO

If NO, please

describe: _____

Describe your strength: (Circle all that apply)

| | | | |
|-------------|------|---------|--------|
| Upper Body: | Weak | Average | Strong |
| Left Side: | Weak | Average | Strong |
| Right Side: | Weak | Average | Strong |

SENSATION:

| | | |
|-------------------------------------|-----|----|
| Is any part of your body paralyzed? | YES | NO |
| Can you feel hot and cold normally? | YES | NO |

If YES to any of the above, please explain: _____

COMMUNICATION:

| | | | |
|---|------|--------|-----|
| Receptive communication level | High | Medium | Low |
| Expressive communication level | High | Medium | Low |
| Can patient make needs known to dental team? | YES | | NO |
| Do you have difficulty speaking or communicating? | YES | | NO |
| Do others have difficulty understanding you? | YES | | NO |
| Do you have difficulty remembering things?: | YES | | NO |
| Do you have difficulty in learning new things?: | YES | | NO |
| Do you have difficulty following directions?: | YES | | NO |
| Do you have difficulty hearing?: | YES | | NO |

If you answered YES to any of these questions, PLEASE EXPLAIN: _____

Useful phrases or words that work best with patient? _____

Does student use non verbal communication? YES NO

If YES:

- Mayer Johnson Symbols
- Sign Language
- Picture Exchange Communication System (PECS)
- Sentence Board or Gestures

Will you be bringing a communication system with you? YES NO

Are there any symbols/signs that we can have available to assist with
communication? _____

VISION:

Do you wear glasses?: YES NO

Do you wear contacts?: YES NO

Please mark any of the following that are true about your vision:

double vision _____

visual perceptual problems _____

can only see to one side _____ Which side, left _____

right _____

HEARING

Do you have a hearing impairment? YES NO

Do you wear a hearing aide? YES NO

If YES, please

explain _____

BEHAVIOR/EMOTIONS:

| | | |
|--|-----|----|
| Impulsive? | YES | NO |
| Do you become easily frustrated? | YES | NO |
| Do you become angry easily? | YES | NO |
| Do you every physically/verbally lose control? | YES | NO |

PLEASE give details to any question that you answered yes to: _____

What are the best ways to help you gain control? _____

Behavior to be discouraged: _____

PLEASE GIVE ANY ADDITIONAL INFORMATION THAT MAY HELP US TO PREPARE FOR A SUCCESSFUL DENTAL EXPERIENCE: _____
