WELL CHILD DENTAL CARE QUESTIONNAIRE: 1-5 YEARS

These questions help us provide better care for your child and support for you. Your answers will be kept private.

Child's Name: _____ DOB: _____ Your name: _____

I am this child's: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other:_____

Please check the box for any topics you would like to discuss today:

❑ Brushing or flossing your child's teeth	❑ What your child eats	❑ Community resources
❑ Your child's behavior	❑ Dental care for you	❑ Other

Do you have specific concerns or questions you would like to discuss today? ❑ No ❑ Yes (Please describe)

_____

_____

Have there been any major changes in your family lately? ❑ None

❑ Move ❑ Job change ❑ Separation ❑ Divorce ❑ Death in family ❑ Family member went to jail

❑ Any other changes or experiences that impacted your family? _____

Please answer a few questions about how you and your child are doing by circling "Yes" or "No"

Does your child still use a bottle?	No	Yes
Does your child use a pacifier or suck on fingers or thumb?	No	Yes
Do you feel your child is more sensitive to brushing teeth or eating certain textures than other kids?	No	Yes
Do *you (parent)* feel anxious or scared at the dentist?	No	Yes
Do you think *your child* feels anxious or scared at the dentist?	No	Yes
Does your child see a doctor for Well Child Care visits? If yes, at NHC or another medical office? (Please circle): NHC medical office Other medical office	Yes	No
Is your child up to date on his/her vaccinations?	Yes	No

In the past week, how many days did (circle one number per question)

1.	You or a family member serve your child fruit or vegetables at *most* meals/snacks?	1	2	3	4	5	6	7
2.	You or a family member serve your child a sugary beverage?	1	2	3	4	5	6	7
3.	You eat at least 1 meal together with your child as a family?	1	2	3	4	5	6	7
4.	You or other family members read to your child?	1	2	3	4	5	6	7
5.	Your child play outside for more than 30 minutes?	1	2	3	4	5	6	7
6.	Your child spend more than 2 hours looking at screens (TV, phone, tablet)?	1	2	3	4	5	6	7

Please answer a few more questions about how you and your family are doing by circling "Yes" or "No"

Does anyone smoke in the home?	No	Yes
Would you like information today about WIC or options for free groceries and meals in your area?	No	Yes
Have **you** (parent) seen your dentist for a check up and cleaning in the past 12 months?	Yes	No