The Fun Kids Dentist
Drs. Trochlell & Assoc.
16655 W. Bluemound Road
Brookfield, WI 53005

SENSORY PROCESSING DIFFERENCES QUESTIONAIRE

Patient Name: _____ Date: _____

Taste

1. Does your child prefer: (Please circle)
   - ✓ Spicy
   - ✓ Sweet
   - ✓ Salty
   - ✓ Strong flavors
   - ✓ Mild flavors
   - ✓ Other, please specify _____

2. Food textures my child **prefers** OR **dislikes**: (Please circle)

✓	Smooth	Smooth
✓	Gritty	Gritty
✓	Sticky	Sticky
✓	No preference	No Preference

3. My child has food sensitivities/aversions. Yes No
   Please explain _____

4. My child feels/tastes hot and cold normally. Yes No
   Please explain _____

Oral Habits

1. My child: (Please circle)
   - ✓ Chews for sensory stimulation
   - ✓ Grinds/clenches teeth
   - ✓ Bites his/her lips
   - ✓ Eats objects (frequency/items chewed) _____

2. Food is used as a reward. Yes No

3. My child uses a mouth guard. Yes No

4. My child has specific dental concerns. Yes No
   Explain _____

Positioning

1. My child would prefer to be: (Please circle)
   - ✓ Reclined in chair
   - ✓ In mom's lap (for infant/toddler)
   - ✓ Seated upright

2. My child would prefer deep pressure touch and would benefit by using a weighted blanket (such as x-ray apron). Yes No

3. My child does not like "light" or "feather" touch. Yes No

4. My child has unusual/unpredictable body movements. Yes No
   Explain _____

Visual

1. My child wears glasses or contacts. Yes No

2. My child has visual perceptual difficulties. Yes No
   Describe _____

3. My child prefers a lighter/darker environment.

4. My child has no visual or light preferences.

Noise

1. My child would prefer: (Please circle)
   - ✓ Quiet/being in a private room
   - ✓ Enjoys seeing other kids & associated noises
   - ✓ Startles easily
   - ✓ Tolerates/enjoys headphones
   - ✓ Responds to calming music (will bring favorite)

Communication

1. My child understands/follows directions. High Medium Low

2. My child expresses desires. High Medium Low

3. Specific words/phrases that work best (if applicable). _____

4. My child prefers directions ; especially if stressed. (Please circle)
   - ✓ Verbal
   - ✓ Written (notes)
   - ✓ Visual (pictures, picture board

Behavior

1. My child becomes frustrated easily. Yes No
2. My child becomes angry easily. Yes No
3. My child benefits from distractions (ie. Television, music, etc.) Yes No
4. My child needs limited distraction. Yes No
5. Impulsive behaviors? Yes No
   Describe:_____
6. Has your child ever had seizures? Yes No

Rewards

Our prize box contains balls, stickers, small figures/animals, rings, etc. Does your child consider these as rewards? (Please circle)

- ✓ Yes
- ✓ No
- ✓ Not real important
- ✓ I will handle reward

Any additional information, you would like to offer, for a successful dental experience. Examples:

- ✓ "fidget" objects
- ✓ Schedule with same hygienist at each visit.