Family History

	YES	NO
1. Does either parent have a history of cavities?	☐	☐
2. Does either parent snore?	☐	☐
3. Does either parent suffer from sleep apnea?	☐	☐
4. Has either parent had traumatic experience (s) at the dentist?	☐	☐
5. How often do parents have dental checkup appointments? _____		

Eating Habits

1. Is your child a good eater?	☐	☐
2. Does your child take a long time to finish a meal?	☐	☐
3. How many snacks does your child eat in an average day?	☐	☐
4. How many gallons of juice/soda does your family consume in a week?	☐	☐
5. Does your child eat small amounts of food throughout the day?	☐	☐
6. As an infant/toddler did he/she drink a bottle/nurse in bed?	☐	☐
7. Do you share food with your children?	☐	☐
8. What type of milk does your child consume?	☐	☐
9. Would you describe your child as being a “grazer”?	☐	☐
10. What is his/her most common snack? _____		

Medical History

1. Has your child had antibiotics?	☐	☐
2. How many ear/throat infections has your child had in the last 12 months?	☐	☐
3. Does he/she suffer from chronic runny nose?	☐	☐
4. Any food Allergies? _____	☐	☐
5. Is your child a good sleeper?	☐	☐
6. Does your child snore while asleep?	☐	☐
7. Does your child drool while asleep?	☐	☐
8. Does your child prefer to breathe thru his/her mouth?	☐	☐
9. Does your child wake up at night?	☐	☐
10. Would you describe his/her as “very active”?	☐	☐
11. Any difficulty sitting still?	☐	☐
12. Does your child have any issues with reading/comprehension?	☐	☐
13. Is your child sensitive to certain sounds/vibration?	☐	☐