

Questions to parents/personnel - about dental health, nutrition and drooling

Name.....National registration no.....

Address.....Postal address.....

Diagnosis.....

Inquiry regarding diagnosis.....

Medication (even dosage).....

RESIDENCE

- At home
 Foster home
 Own home
 Home with special service
 Other habitation.....

DAY-TIME RESIDENCE/ACTIVITIES

- Home
 Day care centre/pre-school
 School Type of school.....
 Work Type of work.....
 Remarks.....

FUNCTIONAL HANDICAP

yes no	insignificant	moderate	severe
<input type="checkbox"/> <input type="checkbox"/> Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Behavioural deviation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Mobility dysfunction			
<input type="checkbox"/> Arm/hand <input type="checkbox"/> Leg			
<input type="checkbox"/> Wheel chair <input type="checkbox"/> Walk with support <input type="checkbox"/> Poor sitting balance			
<input type="checkbox"/> Remarks.....			

Difficulty in communicating

- No speech
 Incomprehensible speech
 Difficulty in understanding other peoples speech
 Alternative communication Which?.....
 Communication aid Which?.....

Other dysfunction

Which?.....

ABOUT DENTAL HEALTH

What is your assessment of the child's/adult's oral hygiene?

- Excellent Fairly good Poor

Where did the child/adult receive dental care?

- Public dental service
 Private dental care
 Hospital dental care
 Specialist dental care
 No dental care

How often does the child/adult receive dental care (including preventive dental care)?time(s) a year

Do you think the child/adult is receiving sufficient dental care?

- yes
 no What is lacking?.....
.....
.....
.....

How does the child/adult experience the dental care received?

Answer this type of question by marking your judgement on the line with an X.

No problems |-----| *Great problems*

If the patient experiences problems in dental care:

To what degree do you think the problems are due to the child's/adult's fear?

Not at all |-----| *Greatly*

To what degree do you think the problems are due to the child's/adult's handicap?

Not at all |-----| *Greatly*

Has the child/adult received any orthodontic treatment?

- yes
- no

Do you think that the child/adult is in need of orthodontic treatment?

No need |-----| *Great need*

Does the child/adult have any of the following problems?

yes no

- Cavities in teeth
- Bleeding gums
- Loose teeth
- Sores in mucous membrane in the mouth
- Bad breath
- Faulty dentition (e.g. protruding front teeth)
- Damaged teeth due to an accident
- Pain in mouth
- Sleeps with open mouth
- Snoring
- Tooth grinding
- Other Which?.....

How does the child/adult manage to brush his/her teeth?

Well |-----| *Not at all*

If help is needed with brushing teeth, how does it proceed?

No problems |-----| *Great problems*

Is the child/adult using any special aids for oral hygiene?

- No
 - Yes What?.....
-

ABOUT EATING HABITS

How does the child/adult handle eating?

No problems |-----| *Extreme problems*

Can the child/adult drink?

No problems |-----| *Extreme problems*

Can the child/adult suck?

No problems |-----| *Extreme problems*

Can the child/adult swallow?

No problems |-----| *Extreme problems*

Does the child/adult have any of the following problems?

yes no

- Chokes on food
- Coughs when he/she receives liquid
- Takes long time to swallow bites of food
- Food/liquid goes up the nose
- Food gets stuck in gums
- Presses tongue forward when swallowing so that much food falls out of mouth
- Swallows large pieces of food without chewing up
- Has difficulty in getting food off spoon with lips
- Food and liquids leak out of corners of mouth
- Has difficulty in opening mouth/jaws
- Sensitive in mouth
- Vomits often (at least twice a week)
- Refuses to eat
- Breast feeding problems as infant Breast fed formonths
- Other Which?.....

What food consistency does the child/adult manage to eat?

- Meat, hard bread etc. (normal food)
- Coarsely mashed food
- Strained food, porridge, puréed food etc.
- Only liquid food Which?.....
- Tube feeding Type of tube?.....
- Parenteral nutrition

Does the child/adult receive enough nutrition?

- Yes
- No

Does the child/adult eat too much?

- Yes
- No

Can the child/adult eat by himself/herself?

- Yes
- To a certain degree
- No, is always fed

Allergic to any food substances?

- No
- Yes Which substance(s)?.....

Special diet or additional diet?

- No
- Yes What?.....

Number of meals per day (including snacks).....

How long does it take to eat a main meal? Approx.....minutes

Give your weight and height Weight.....kg Height.....cm

Seating during meals.....
.....

What aids are used to eat with?.....
.....
.....

ABOUT DROOLING

Does the child/adult drool?

- Yes
- No (do not answer the questions below)

- Slight drooling, only lips
- Moderate drooling, lips and chin
- Profuse drooling, over clothes
- Very profuse drooling, on hands and objects

How do you think the child/adult experiences his/her drooling?

No problem |-----| *Serious problem*

How do you experience the drooling as parent/attendant?

No problem |-----| *Serious problem*

How do you think people around the child/adult experience the drooling?

No problem |-----| *Serious problem*

Has anything been done to treat the drooling?

- No
- Yes What?.....
.....
Result.....
.....

Questionnaire answered by:

Parent Attendant Other.....

I consent to having this questionnaire forwarded to the Mun-H-Center.

Place and date.....

Signature.....
Signature of patient, guardian or good man