First name: _____ **Age**: ___ y ___ mos
Date: _____

Diet Information	**Yes**	**No**
For 3 year olds, Weaned? …….	____	____
Age when weaned_____		
Sleep with a bottle?.....	____	____
Eats Fruits and Vegetables?.....	____	____
Drinks Soda?.....	____	____
Cans per week_____		
Drinks Juices / 'Ades?.....	____	____
Glasses per week……..		
Likes to Brush and Floss.....	____	____
How often per day……		
Who Brushes……		
Fluoride Supplements?……..	____	____
Likes Candy/Sweets?.....	____	____
How often per week		
Problems with other adults supplying sweets	____	____
Other Information		
School Grade……..		
Plays any sports……..	____	____
Which ones…….		
Uses a mouthguard?.....	____	____

NP/Rec

*** Please see reverse side ***

Do you have any concerns regarding your child and the following habits?

	Yes	**No**
Grind teeth?	____	____
Bites cheek?	____	____
Tongue thrust?	____	____
Mouth breather?	____	____
Bulimia / Anorexia?	____	____
Smoking?	____	____
Bite nails?	____	____
Smokeless tobacco?	____	____
Thumb / finger sucker?	____	____
Toothpick use?	____	____
Chewing gum?	____	____

Child's Physician: _____

Dr. Contact Phone Number: _____

Referred By: _____