Caries Risk Assessment

CHILD'S NAME _____ CHILD'S AGE _____

PARENT'S NAME _____ DATE _____

PLEASE COMPLETE EACH QUESTION TO THE BEST OF YOUR KNOWLEDGE.

Does your child brush in the morning and at night? YES NO

Does your child brush with fluoride toothpaste? YES NO

Does an adult help? If so, when? _____ YES NO

Are your child's teeth flossed? YES NO

If so, how often? By whom? _____

Do you have any other children with active dental decay? YES NO

Your child usually drinks: (circle one) Tap water Bottled water Filtered water

Has your child ever been to the dentist before? YES NO

If so, have they had previous restorations (fillings) or appliances made? YES NO

Have you ever noticed your child's gums bleeding, any discolorations, or evident plaque? YES NO

If so, please describe: _____

Has your child ever had any trauma to a tooth? YES NO

If so, when and how? _____

Does your child have any developmental problems? YES NO

If so, please describe: _____

Does your child drink anything other than water at bedtime, after brushing? YES NO

If so, what? _____

Have you (parent) or your child's primary caregiver had any cavities in the last two years? YES NO

Does your child have any oral habits? (circle all that apply)

Pacifier Thumbsucking Sucks fingers Grinds teeth Other: _____

What does your child snack on during the day? _____

How many times a day do they snack? (circle one) 1-3 times 3+ times

What does your child usually drink at meals? Water Juice Milk Other: _____

What does your child sip on during the day? Water Juice Milk Other: _____