

**Pre-Treatment Assessment Form Part II
To Be Completed by Doctor**

Clinical Behavior

- | | |
|--|---|
| <input type="checkbox"/> Does Not Seem to Understand | <input type="checkbox"/> Temper Tantrum |
| <input type="checkbox"/> Does Not Make Eye Contact | <input type="checkbox"/> Covers Mouth or Face |
| <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Won't Lay Back |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Won't Lay On Back |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Kicks Feet |
| <input type="checkbox"/> "Fighter" | <input type="checkbox"/> Won't Get In Chair |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Rubbing Eyes |
| <input type="checkbox"/> Screaming | <input type="checkbox"/> Talks Fresh |
| <input type="checkbox"/> Spitting | <input type="checkbox"/> Other (specify) |

(This form helps the doctor to assess what the issues are from the perspective of completing the dental treatment.)