Personal Information

Name:_____

Address: _____

City:_____ State:_____ Zip Code:_____

1. Phone Number: Home: _____

   Cell:_____

   Work:__ _____
2. Email address:_____
3. Preferred method of contact: □ Cell Phone □ Home Phone □ Email
4. Date of Birth: _____
5. Age: _____

Dental / Medical Information:

1. Are you under the care of a physician? _____
   - If yes, what condition is being treated? _____
2. Name and address of Primary Care Physician:_____
3. When was your last check up with your Physician:_____
4. Name and address of General Dentist:_____
5. Date of last dental exam: _____
6. Have you been hospitalized over the last 5 years? _____
   - If yes, why?_____
7. Are you taking any drug, diet supplement or medication at this time?_____
   - If yes, please list name and dosage _____
8. Are you allergic to any medication, product (i.e. latex) or food? _____
   - If yes, which one? _____

9. Have you ever been treated or advised that you have any of the following? Circle all that apply

Speech Disorder *Recurrent Sinus Infections* *Recurrent Ear Infections*

Heart Issues *Diabetes* *Recurrent Upper Resp. infections*

Neurological Disorder *Cancer* *Headaches* *Asthma*

Pain in the jaw joint *Arthritis* *Bedwetting* *Drug Dependency*

Stroke *Chronic Cough* *ADD/ADHD* *Acid Reflux*

Other:_____

10. Have you had orthodontic treatment:_____

11. Orthodontist Name: _____

12. Orthodontist Address: _____

13. Please briefly describe your orthodontic treatment? (i.e. palatal expansion followed by braces for "X " years, oral surgery, teeth extraction, etc…) ___

_____

_____

14. Have you had any orthodontic relapse? □ Yes □ No

15. Do you wear a retainer? □ Yes □ No Do you wear a night guard? □ Yes □ No

16. Do you suffer from allergies? □ Yes□ No Are you stuffy or congested all the time?□ Yes□ No

If yes, to what? Medication used ?_____

17. Allergist Name: _____

18 Allergist Address: _____

19. Have you had your tonsils / adenoids removed? □ Yes □ No What age?_____

20. Did you use a pacifier? □ Yes □ No □ Unknown Suck your thumb/fingers? □ Yes□ No □ Unknown

Had trouble breast or bottle feeding as a child ? □ Yes□ No □ Unknown

21. Do you suffer from any of the following? Circle all that apply

Tooth wear *Gum Inflammation* *Periodontal Disease*

TMJ pain *Gas/Burping*

General Information

1. Have you ever had any injury involving your mouth, head, neck, or shoulder?_____

If yes, please describe the injury and treatment: _____

2. Do you suffer from any disease or disorder affecting muscle strength or muscle movement (i.e. Cerebral Palsy, Bell's Palsy, Fibromyalgia)?_____

If yes, please describe the disease or disorder: _____

3. Do you play a musical instrument?_____

If yes, which one? Number of hours of practice a day?_____

4. Do you play any sport? _____

If yes, which one? Number of hours of practice a day?_____

5. Do you grind your teeth?_____

6. Do you sleep on your right or left side / back / stomach? _____

7. Do you suffer from sleep apnea?_____

If yes, do you use a C-PAP machine? _____

8. Do you have any of the following habits? Circle all that apply

Chewing on a pen *Sucking your tongue* *Chewing on hair*

Chewing more than one piece of gum a day *Nail biting*

Chewing inside of your cheeks *Biting your lip* *Smacking your lips*

Resting your face in your hand *Licking your lips* *Wake up during the night to drink water*

9.Have you noticed any of the following : circle all that apply

Dry mouth *Wake up tired* *Have anxiety and or panic attacks*

Tend to have a lot of cavities *Bad breath* *Digestion issues* *Fast - irregular breathing* *Sigh a lot*

Have audible breathing *Drool marks on pillow* *Restless sleep* *Snoring* *Chapped lips often*

10. Do you frequently get cold sores, blisters, or any other oral lesions?_____

11. Do you have tired jaws, especially in the morning?_____

12. Have you noticed any change in your teeth or change in your bite?_____

13. Do you mouth breathe when you are asleep?_____

14. Do you mouth breathe during the day?_____

15. Do you hear any click, pops or grating sounds in your jaw joints?_____

16. Has your jaw ever locked opened or closed?_____

17. Have you ever had jaw surgery?_____

18.Do you have difficulty swallowing pills?_____

19. What are your goals for orofacial myofunctional treatment?_____

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20. Who can we thank for referring you to us?_____

Client's signature: _____Date :_____