Personal Information

Name: _____ Parent/Guardian 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: _____Age:_____

Dental / Medical Information:

1. Is your child under the care of a physician? _____

   - If yes, what condition is being treated? _____

2.Primary Care Physician:_____

Primary Care Address:_____

Date of last medical checkup:_____

3. General Dentist:_____

Address and Phone number:_____

Date of last exam:_____

4.Has your child been hospitalized during the past 4 years? □ Yes □ No

   - If yes, why?_____

5. Is your child taking any drug or medication at this time?_____

   - If yes, please list name and dosage _____

6. Is your child allergic to any medication, product (i.e. latex) or food? _____

- If yes, which one? _____

7. Has your child ever been treated or had any of the following? Circle all that apply

Speech Disorder *Acid reflux* *Recurrent Sinus infections* *Epilepsies*

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

Neurological Disorder *Headaches* *Asthma* *Bedwetting*

Autism Chronic Cough *ADD/ADHD* *Ear tubes placed* *Recurrent Ear Infections*

*Other:*_____

8. Has your child had his/her tonsils / adenoids removed? □ Yes □ No What age?_____

9. Does your child suffer from allergies? □ Yes □ No

If yes, to what?_____ Medicine taken?_____

10.Are they stuffy or congested all the time? □ Yes □ No

11. Allergist Name: _____

12. Allergist Address: _____

General Information

1.Did or does your child have any issues with breastfeeding and /or bottle feeding? □ Yes □ No

- If yes please describe:_____

2. Did or does your child have any of these issues with early feeding? Circle all that apply

Excessive burping *Projectile vomiting* *Excessive spit-up*

GERD *Gagging* *Fatigued easily* *Choking*

Excessive drooling *Allergies/sensitivities* *Lip-tie* *Ankyloglossia*

3.Did or does your child use a pacifier? □ Yes □ No Suck thumb/fingers? □ Yes □ No

- If yes, do they still? □ Yes □ No

4. Has your child every had an injury involving their head, neck, shoulder or mouth?_____

If yes, please describe the injury and treatment: _____

5. Does your child suffer from any disease or disorder affecting muscle strength or muscle movement (ie: Cerebral Palsy)

If yes, please describe the disease or disorder: _____

6. Does your child grind their teeth?_____

7. Does your child sleep on their back/side (Left/right) stomach:_____

8. Does your child have any of the following habits? Circle all that apply

Object chewing *Sucking on their tongue* *Chewing on hair*

Nail biting *Chewing inside of cheeks* *Biting their lip*

Smacking their lips *Licking their lips*

Sweat at night *Wake up several times during the night*

9. Does your child avoid any foods?_____

- If so, which ones?_____

10. Does your child mouth breathe when they are sleeping?_____

11. Does your child mouth breathe during the day or have their mouth open during the day?_____

12. Is your child able to swallow pills?_____

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

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

Dry mouth *Stuffy/congested nose all the time* *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*

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

_____

Parents signature: _____Date :_____

Additional

Notes :_____

_____

_____

_____

_____

_____