Oral Function SPECIALTIES

Connecting oral health and wellness through a lifetime

Name: _____ Nick Name: _____ DOB: _____

Parent/Caregivers Name: _____

Date of last medical exam:_____ Date of last dental exam: _____

Has your child's vision been tested: _____ Has your child's hearing been tested: _____

Please give a reason for your visit today:_____

Is your child under the care of a physician? _____ yes _____ no

Does your child have any medical/developmental diagnoses being treated? _____

Is your child taking any medicines, drugs or nutritional supplements now? _____ yes _____ no

If yes, please list: _____

Is your child allergic to any medications, foods, drugs or latex? _____ yes _____no

If yes, please list: _____

Does your child have any allergies that make their nose stuffed on a regular basis? _____yes _____no

Does your child have a tendency towards strep, headaches or ear infections? _____yes _____no

If yes, please list which ones and frequency: _____

Has your child ever been injured in the head, neck, back or pelvic region? _____yes _____no

If yes, please explain: _____

Does your child have any jaw pain or popping sounds? _____yes _____no

Does your child clench or grind their teeth? _____yes _____no

Does your child bite their cheeks, tongue or lips regularly? _____yes _____no

Does your child breathe through their mouth during the day or at night time? _____yes _____no

Does your child hold foreign objects with their teeth? (pencils, clothes, fingernails) _____yes _____no

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Does or has your child ever sucked their thumb, fingers or a pacifier? ____yes ____no

If yes, when did habit begin or how long did they have habit? _____

Was your pregnancy normal with a full term delivery? ____yes ____no

Was your child nursed or bottle fed? _____ nursed, how long? _____ bottle fed, how long?

Was your child on track for motor development (crawling, walking, babbling)? _____ yes ____ no

Does your child have a history of:

____ Allergies/Hay Fever/Asthma

____ Swallowing issues

____ Speech therapy

____ ADD/ADHD

____ Trouble sleeping

____ Frequent ear infections

____ Seizures

____ Dental/orthodontic treatment

____ Snoring

____ Feeding difficulties

____ Digestive disturbances

____ TMJ Pain

____ Headaches

____ Family history of developmental delay

____ Tinnitus

____ GERD/Reflux

____ Frequent colds/ strep or sinus infections

____ Failure to thrive

____ Serious illness, injuries, hospitalizations

____ Food allergies

____ Messy/noisy eater

____ Difficulty swallowing pills

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Do you have any other physical condition, disease, problem or concern not addressed above?
_____ yes _____no

If yes, please list: _____

_____

_____

_____

I understand the above information is necessary to provide me with an orofacial myofunctional program in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify my therapist of any change in my health or medication.

Patient/parent signature: _____ Date: _____