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: _____