Oral Function SPECIALTIES

Connecting oral health and wellness through a lifetime

General Information

Name (First, M.I., Last) _____ Nick Name _____
Date of Birth _____
Address _____ Home Phone _____ Cell _____
City, State, Zip _____ Email _____
Occupation _____ Work Phone _____
Check _____ Single ____Married ____Divorced ____Widowed ____Separated
If married, spouse's name _____
Person financially responsible for account _____
Relationship to patient _____
Person to contact in an emergency _____ Phone _____
Dentist _____ Phone _____
Orthodontist _____ Phone _____
Physician _____ Phone _____
Speech Therapist _____ Phone_____
Whom may we thank for referring you to us? _____
Please describe why you are seeking an evaluation _____

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

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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

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

_____ TMJ Pain

_____ Headaches

_____ Family history of developmental delay

_____ Tinnitus

_____ GERD/Reflux

_____ Frequent colds/ strep or sinus infections

_____ Failure to thrive

Phone Number: (708) 316-1610 • Email: SpotOnMyo@gmail.com • Website: OralFunctions.com

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_____ Dental treatment

_____ Snoring

_____ Feeding difficulties

_____ Digestive disturbances

_____ Seen an ENT

_____ Had tonsils or adenoids removed

_____ Serious illness, injuries, hospitalizations

_____ Food allergies

_____ Messy/noisy eater

_____ Difficulty swallowing pills

_____ Had a sleep study

_____ Had orthodontic expansion

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: _____

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