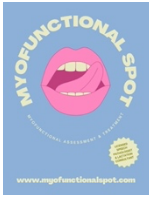

Dena Freedman-Muchnick, M.S., CCC-SLP, CLC
Speech Language Pathologist
Certified Lactation Consultant
(954) 261-9864
www.myofunctionalspot.com

Infant Myofunctional Screening

First Name:_____________________ MI:__ Last Name:______________________
DOB:___/___/_____
Examination Date:____
Birth Weight:_________lbs.______oz Current Weight:________lbs._____oz
Parent / Guardian Name (1): ____
Phone Number: ____
Parent / Guardian Name (2): ____
Phone Number: ____
Address: ____
City: _________________________ State: ____________ Zip: ____________
E-Mail Address: ____

Lactation Consultant: ____
Pediatrician: ____
What is your chief concern today:
____
____

Family History (any frenulum alteration or lip/tongue releases) ( ) yes ( ) no
Who: ______________________________ What: __________________________

Any other health problems your baby has experienced? ( ) yes ( ) no
What: ____

Baby's Symptoms:

Poor Latch ( )
Falls asleep while nursing ( )
Slides Off ( )
Colic Symptoms ( )
Reflux Symptoms ( )
Poor Weight Gain ( )
Short Sleep Periods ( )
Unable to hold a pacifier in their mouth ( )

Mother's Symptoms:

Creased, flattened or blanched nipples after nursing ( )
Cracked, bruised or blistered nipples ( )
Bleeding Nipples ( )
Pain when your infant attempts to latch ( )
Infected nipples or breasts ( )
Plugged ducts ( )
Gumming or chewing of nipples when nursing ( )
Mastitis or nipple thrush ( )

Family History of Tongue Tie? ( ) yes ( ) no Lip Tie? ( ) yes ( ) no

Has your baby had any of the following?

Weight loss/gain ( )
Swallowing issues ( )
Breathing issues ( )
Bleeding problems ( )
Nasal Obstructions ( )
Cyanosis (turning blue) ( )
Reflux / Vomiting/Spitting Up ( )

I consent to the exam and evaluation and understand this is a screening of my child's potential lip/cheek/tongue restrictions. I hereby expressly waive any and all claims which I might, at the time, have given Dena Freedman-Muchnick, M.S., CCC-SLP, CLC, her employees, and agents, in any manner whatsoever relating to said testing. I acknowledge HIPPA regulations.

Parent / Guardian Name (Print) Date

Parent / Guardian Signature

Dena Freedman-Muchnick M.S., CCC-SLP, CLC