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

Adult Patient Intake

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____
D.O.B.: _____ Gender: _____ Marital Status: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone Number: _____ Email: _____
Whom shall we contact in a medical emergency? _____ Phone #: _____
Whom may we thank for referring you to me? _____

Describe the problem about which you are most concerned about? _____
_____

How long have you had this problem? _____
_____

Does anything make it better or worse? _____
_____

Is this problem currently giving you pain? ___ Yes ___No If yes, where, and how much pain? ____
_____

What result would you like to achieve through treatment here at Myofunctional Spot? _____
_____

Medical History

Please list age at diagnosis and any additional details

Current Primary Physician: _____ Phone Number: _____
Current Dentist: _____ Phone Number: _____
Current Orthodontist: _____ Phone Number: _____
Any Other Specialists? _____

Do you currently see a sleep specialist? _____ Yes _____ No If yes, who? _____
Would you like to inform either provider about your treatment? _____ Yes _____ No
Has your child ever had surgery? _____ Yes _____ No

____ Lingual Frenum Restriction (tongue tie) _____
____ Labial Frenum Restriction (lip tie) _____
____ Buccal Frenum (cheek tie) _____

Previous surgeries? ____ Yes ____ No
If yes, please provide details _____
_____

Any other medical history that you would like me to know? _____
_____
Are you currently under medical care for any medical conditions? ____ Yes ____ No

If so, please provide me with details. _____
_____

Do you take medications, including over the counter and supplements? ___ Yes ___ No If yes, please list the name and dosage below.

Medication Name	Dose	Medication Name	Dose

Have you ever had an allergic reaction to any medications and/or substances? ___ Yes ___ No If yes, please list them below.

Medication / Substance	Description of Reaction

Do you suffer from any seasonal allergies? ___ Yes ___ No If yes, please list them: _____
_____

Do you currently have or have had a history of any pain, medical disorders or diseases? ___ Yes ___ No If yes, please check all that apply.

It is especially important to know if you had any of these as a child

__ Pain in the teeth or gums	__ Frequent headaches or migraines	__ High/Low B.P.
__ Pain in the joints of jaw	__ Neck pain	__ Anemia
__ Trouble chewing	__ Numbness in arms or hands	__ Asthma
__ Trouble speaking	__ Paralysis / loss of sensation	__ Emphysema
__ Trouble swallowing	__ Snoring	__ COPD / Shortness of breath
__ Clicking/Grinding of jaw joints	__ Daytime sleepiness	
__ Pain when opening/closing jaw	__ Frequent awakening	__ Chest pain
__ Difficulty opening/closing jaw	__ Tooth grinding while sleeping	__ Arthritis
__ Pain inside of the ear	__ Obstructive sleep apnea	__ Hepatitis

__ Clogged or stuffy ears __ Difficulty hearing __ Ringing in ears __ Ear infections __ Sinus infections	__ Restless leg syndrome __ Nasal congestion __ Nasal drainage __ Strep infections __ Gastric reflux	__ HIV / AIDS __ Tuberculosis __ Mononucleosis __ Bronchitis __ Pneumonia

Do you suffer from any sleeping disorders or use any devices to assist you in sleeping? ___ Yes ___ No
If yes, please answer the following questions:
Have you tried using a dental device for OSA or snoring?___ Yes ___ No If yes, which? _____
Have you tried using a Continuous Positive Air Pressure (C-PAP) device? ___ Yes ___ No If no, please indicate why: _____
_____
Are you currently pregnant? ___ Yes ___ No If yes, when is the due date? _____
Have you gone through menopause? ___ Yes ___ No
Are you currently having any dental work done?___ Yes ___ No
Have you ever worn a dental splint? ___ Yes ___ No
Do you currently smoke? ___ Yes ___ No ___ Used to
If yes, please indicate the following: ___ Number of packs a day ___ Years smoking
Do you drink alcohol? ___ Yes ___ No
Any other substances that may impact your health in a significant manner (i.e. illegal, harmful substances): _____

Have you had any major surgeries within the past 10 years? ___ Yes ___ No If yes, please list all major surgeries: _____
_____

Developmental/Feeding History
(you may need to research this a bit)

Were there any difficulties with your pregnancy or with your delivery? ____ Yes ____ No
Was your child breast or bottle fed (circle one)? How long? _____
Were there initial breast/bottle feeding difficulties as an infant/toddler?
_____
Difficulty with latch? _____ Poor Milk Supply? _____ Reflux? _____

Were your child's developmental milestones within normal limits? ____ Yes ____ No
Age child sat up? ____ Age child rolled over? ____ Age child crawled?____ Age child walked? ____
Age child said first word? ____ Age child fed self? ____ Age child began eating solids? ____
Any trouble with speaking, speech sounds? _____
Any sensory concerns as a child? _____
How did transition to solids go? _____
Did child prefer/avoid certain foods and/or consistencies? _____
Did child drink from a sippy cup? _____

Age child drank from a straw? _____
Has your child ever sucked their (check all that apply)
____ Thumb ____ Finger(s) ____ Pacifier
When did the habit stop? _____
Does your child have a history of other oral habits? Indicate if still present.
____ Lip licking ____ Lip sucking ____ Cheek biting/sucking ____ Nail biting
____ Other oral habits? _____
How is the child's general health? _____
History of frequent ear infections? _____ Ear Tubes? _____
Chronic Upper Respiratory Infections/Colds? _____

Any history of speech therapy? ____ Yes ____ No
Name/How Long _____

Any history of attending occupational therapy? ____ Yes ____ No
Name/How Long _____

Any history of physical therapy sessions? ____ Yes ____ No
Name/How Long _____

Present Eating Habits

Are you a fast or slow eater? ___ Fast ___ Slow

Do you drink more than one glass of liquid with meals?	___ Yes ___ No
Do you wash down food with liquid during a meal?	___ Yes ___ No
Do you chew your food adequately?	___ Yes ___ No
Do you choke easily?	___ Yes ___ No
Do you gag easily?	___ Yes ___ No
Do you belch often?	___ Yes ___ No
Do you have digestive problems?	___ Yes ___ No
History of reflux?	___ Yes ___ No
Are you a noisy eater (lip/tongue smacking)?	___ Yes ___ No
Are you a messy eater?	___ Yes ___ No
Is there an audible gulping sound when swallowing?	___ Yes ___ No
Do you chew with lips apart/mouth open?	___ Yes ___ No
Do you avoid any foods due to difficulty chewing?	___ Yes ___ No
Do you avoid any foods due to texture issues?	___ Yes ___ No
Do you have difficulty swallowing pills?	___ Yes ___ No

Dental History

Were your baby teeth normal?	___ Yes ___ No
Were baby teeth lost at normal ages?	___ Yes ___ No
History of any dental anomalies?	___ Yes ___ No
Do you have a history of cavities or periodontal disease?	___ Yes ___ No

Other oral concerns? ___ Yes ___ No If yes, explain: _____
Have permanent teeth been injured/chipped/extracted? ___ Yes ___ No
List any prior orthodontic treatment you have received: _____

Do you experience any of the following: (Check all that apply)
___ Clicking of the jaw
___ Popping of the jaw
___ Pain in the jaw
___ Facial pain
___ Bruxism Day (grinding of the teeth)
___ Bruxism Night (grinding of the teeth)
___ Teeth/jaw clenching (day)
___ Teeth/jaw clenching (night)

Other Related Questions

Do you usually rest with lips together or open? _____
While sitting idle, do you need to breathe through your mouth or nose? _____
Do you find that your mouth is open while watching TV? ___ Yes ___ No
Do you often feel sleepy or tired during the day? ___ Yes ___ No
Do you take naps during the day? ___ Yes ___ No
Do you fall asleep while involved in a quiet activity? ___ Yes ___ No
Additional details with sleep pattern? ___ Yes ___ No
Do you have any concerns related to speech or sounds? ___ Yes ___ No
Do you have a history of: (check all that apply)
___ Snoring
___ Dry mouth in the morning
___ Sleep with mouth open
___ use sleep medication
___ Unrefreshing/Restless sleep
___ Neck/Shoulder pain
___ Wake up gasping for air
___ Drool during the night (wake up with wet pillows)
___ Difficulty opening or closing your mouth while chewing

Additional Questions

What is your current profession? _____
Do you work in the home or outside the home? _____
Physical requirements for your job? _____
Any previous careers/work environments? _____

Please describe your personality? _____
_____

What do you hope to achieve from this evaluation/treatment? What are your primary goals? _____
_____

Describe the problem you are experiencing and how it interferes with your life? _____
_____

What do you think caused or attributed to this problem? _____

Have you already tried to fix the problem? _____

Is there anything else you would like me to know about you prior to treatment beginning? _____
_____

_____
Patient Name (Printed)

_____
Patient Signature

_____
Date