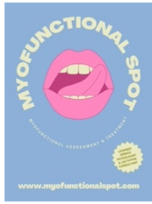

Dena Freedman-Muchnick, M.S., CCC-SLP, CLC
Speech Language Pathologist
Certified Lactation Consultant
(954) 261-9864
www.myofunctionalspot.com

Child/Adolescent Patient Intake

First Name: ______________________ Middle Initial: ____ Last Name: ________________________
Date of Birth: ______/______/______ Gender:_______________________
Street Address: ____________________ City: ______________________ State:______ Zip:__________
Preferred Phone Number: ____________________________ Email: ____________________________
Parent/Guardian 1 First Name: ________________________ Last Name: ________________________
Relationship to minor: __________ Phone Number: _________ Email: ____________________________
Parent/Guardian 1 Profession: ____
Parent/Guardian 2 First Name: ________________________ Last Name: ________________________
Relationship to minor: __________ Phone Number: _________ Email: ____________________________
Parent/Guardian 2 Profession: ____

Whom may we thank for referring you to me? ____
What is the reason for visiting my practice? (check/circle all that apply)
_____ Snoring/Sleep Issues
_____ Frenulum Evaluation
_____ Pre/Post Frenectomy
_____ Myofunctional Therapy
_____ Feeding Concerns
_____ Mouth Breathing
_____ Tongue Thrust
_____ Referred by a dental/medical professional
Other reasons (please list): ____

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. ____
____

Does your child take any medications, including over the counter and supplements? _____Yes _____No
If yes, please list the name and dosage below:

Medication Name	Dose	Medication Name	Dose

Has your child ever had an allergic reaction to any medications and or substances? _____ Yes _____ No
If yes, please list them below:

Medication / Substance	Description of Reaction

Does your child suffer from any seasonal allergies? _____ Yes _____ No
If yes, please list them:
____
____

Does your child currently have or have had a history of pain, medical disorders/diseases?___Yes ____No
If yes, please check all that apply below:

____ Pain in the teeth or gums
____ Pain in the joints or jaw
____ Trouble chewing
____ Trouble speaking
____ Trouble swallowing
____ Migraines
____ Difficulty opening/closing jaw
____ Open mouth breathing
____ Tooth grinding while sleeping
____ Difficulty breathing through nose
____ Pain inside of the ear
____ Clogged of stuffy ears
____ Ringing in ears
____ Ear infections
____ Difficulty hearing
____ Snoring
____ Nasal congestion
____ Nasal drainage
____ Obstructive sleep apnea
____ Sinus infections
____ Noisy Breathing at night
____ Asthma
____ Neck pain
____ Chest pain
____ Frequent headaches
____ Difficulty concentrating
____ Daytime sleepiness
____ Strep Infections
____ Gastric reflux
____ Restless leg syndrome

Developmental/Feeding History

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 ____

Other therapies/interventions? ____

Present Eating Habits for Adolescent

Are you a fast or slow eater? (circle one)
Do you drink more than one glass of liquid with meals? ____ Yes ____ No
Do you wash down food with liquids during a meal? ____ Yes ____ No
Do you chew your food adequately? ____ Yes ____ No
Do you choke easily? ____ Yes ____ No
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

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 baby teeth normal? _____ Yes _____ No
Were baby teeth lost at normal ages? _____ Yes _____ No
History of any dental anomalies? _____ Yes _____ No
Is there a history of cavities or periodontal disease? _____ Yes _____ No
Other oral concerns? _____ Yes _____ No
Have permanent teeth been injured/chipped/removed? _____ Yes _____ No
History of palate expansion? _____ 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 your lips together or open? ____________________________________
While sitting idle, do you tend to breathe through your mouth or nose? ________________________
Do you find that your mouth is open while watching TV or on computer? _____ 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 when involved in a quiet activity (watching TV, reading, etc.)? _____ Yes _____ No
Additional details with sleep pattern? ____
Do you have any concerns related to your speech or pronunciation? _____ Yes _____ No
Do you have a history of: (check all that apply)
_____ Snoring
_____ Mouth breathing during day
_____ Sleep with mouth open
_____ Use sleep medication
_____ Dry mouth in the morning
_____ Unrefreshing/Restless Sleep
_____ Neck/Shoulder pain

____ Wake up gasping for air
____ Drool during the night (wake up with wet pillow)
____ Difficulty opening or closing your mouth while chewing

What is your current profession? ____
Do you work in the home or outside the home? ____
Physical requirements for your job? ____ Yes ____ No
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? ____
____

What have you already tried to fix the problem? ____
____

Is there anything else that you would like me to know about you prior to treatment beginning? _______
____

______________________________	______________________________
Parent/Guardian Signature	Parent/Guardian Name (Print)
______________________________	______________________________
Patient Signature	Patient Name (Print)

____
Date