



# Parent Assessment Form

\*Please answer the questions below to the best of your knowledge. This form will provide a basis for my exam and allow me to focus on the specific symptoms you experience. A thorough exam of all your symptoms will be completed on day of consultation.

- 1) \_\_\_ Has your child ever had a thumb or finger sucking habit?
- 2) \_\_\_ Has your child ever had allergies or food sensitives?
- 3) \_\_\_ Do you notice that your child has their mouth open at rest?
- 4) \_\_\_ Has your child ever had trouble with speech or been in a speech therapy program?
- 5) \_\_\_ Has anyone every told you that your child may be tongue- tied?
- 6) \_\_\_ Did your child have difficulties feeding as an infant?
- 7) \_\_\_ Has your child experienced any issues with digestion? (Stomach aches, burping, gas, acid reflux, etc.)
- 8) \_\_\_ Do you notice that your child has a hyper-active gag reflex?
- 9) \_\_\_ Does your child have difficulty swallowing pills?
- 10) \_\_\_ Does it seem like your child is a messier eater than other kids? (Chews with mouth open, drinks and chews at same time etc.)
- 11) \_\_\_ Has your child experienced any breathing issues or difficulties? (Chronic congestion, asthma, seasonal allergies, etc.)
- 12) \_\_\_ Has your child had their tonsils removed, or have you been told the tonsils are enlarged?
- 13) \_\_\_ Do you notice that your child tends to breathe through their mouth more often their nose?

\*\* Generally, if any of these questions can be answered "yes", your child is likely to have some myofunctional concerns. If you can answer "yes" to multiple questions, myofunctional therapy will be recommended.

Please print or email back to Melanie prior to consultation  
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