Today's Date:

MEDICAL HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I) :* ☐ M ☐ F ☐Other	**DOB:**
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Patient's Address:	
Parent's Name (if minor):	**Occupation:**
Phone number:	**Email Address:**
Name of your physician:	**Date of last physical examination:**
Whom may we thank for referring you:	
Chief complaint:	

PERSONAL HEALTH HISTORY		
Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other_____		
Immunization Dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR Measles, Mumps, Rubella

List any medical problems that any doctors have diagnosed					
Premature Birth	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Feeding Disorder	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Any Seizures	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Do you have problems with eating/appetite?	☐ Yes	☐ No	Any other heart Condition	☐ Yes	☐ No
Chronic Otitis Media	☐ Yes	☐ No	Chest Pain/ Shortness of Breath	☐ Yes	☐ No
Nasal Obstruction	☐ Yes	☐ No	High/Low Blood Pressure	☐ Yes	☐ No
Enlarged Tonsils/Adenoid	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No	Lung Problem	☐ Yes	☐ No
Sinus Infection	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Snoring	☐ Yes	☐ No	Liver Problems	☐ Yes	☐ No
Any Reflux	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Deviated Septum	☐ Yes	☐ No	Do you panic when stressed?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No	ADD/ADHD	☐ Yes	☐ No
Headaches or Migraines	☐ Yes	☐ No	Do you feel Depression?	☐ Yes	☐ No
Neck or shoulder pain or tension	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Genetic Disorder	☐ Yes	☐ No	Mouth Open/ Mouth Breathing	☐ Yes	☐ No
Blood Diseases	☐ Yes	☐ No	Celiac Disease	☐ Yes	☐ No
Other:					

Surgeries		
Year	**Reason**	**Hospital**
Other Hospitalizations		
Year	**Reason**	**Hospital**
Have you ever had a blood transfusion?		
If yes, please explain:		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Name the drug	Strength	Frequency taken

Allergies:	
Name of the Drug you allergic to:	Reaction you had
Any other Allergies:	☐ Pollen ☐ Dust ☐ Trees ☐ Red Dye ☐ Grass ☐ Latex ☐ Bee Stings ☐ Food _____ ☐ None ☐ Other _____

Food Intolerances:
☐ Gluten ☐ Dairy ☐ Red Dye ☐ Shellfish ☐ Nuts ☐ Eggs Others: _____

Prenatal History:		
☐ Normal	☐ Atypical	☐ Complications
Describe Complications:		
Prenatal Term: ☐ 40+ weeks ☐ 39-37 weeks ☐ 36-33 Weeks ☐ Other		
Describe complications:		

Labor and Delivery:			
Normal	☐	Protracted Labor	☐
Induced	☐	Forceps	☐
C-Section	☐	Vacuum	☐

Describe Complications:

Developmental History:		
Milestones:	**On Time**	**Delayed**
Held head up		
Rolled over		
Walking		
Running		
Coloring		
Writing		

History of Intervention:			
	Name	Contact Info	Reason
☐ Speech Therapy			
☐ Occupational Therapy			
☐ Physical Therapy			
☐ ABA Therapy			
☐ Other Therapy			

Speech:	
☐ Frustration with communication	☐ Lisp
☐ Difficult Speaking Fast	☐ Stuttering
☐ Trouble with Sounds (Which?)	☐ Mumbling or Speaking Softly

Sensory System:
☐ Light ☐ Sound ☐ Texture ☐ Self-regulation ☐ Hypersensitive ☐ Other:

Sleeping Pattern:		
Are you a good Sleeper?	☐ Yes	☐ No
Have you ever had concerns about your child's sleep? Explain below	☐ Yes	☐ No

Oral Habits:			
	During Day	At Night	Resolved By
Pacifier			
Thumb/Digit			
Objects			

Feeding History			
Infant History:			
☐ Breastfed	☐ Bottle Fed Breastmilk	☐ Bottle fed	☐ Nasogastric Tube
Feeding Characterized By:			
☐ Difficulty with Latch		☐ Reflux	
☐ Gastric Discomfort after eating		☐ Absence of Phasic bite reflex	
☐ Poor Suck Skill		☐ Poor Milk Supply	
☐ Needed a nipple Shield		☐ Labial Tie	
☐ Mastitis infections		☐ Tongue Tie	
☐ Poor Rooting Reflex			
Infant/Children/Adult:			
☐ Frustration when eating		☐ Packing food in cheeks	
☐ Difficulty Transitioning to solid food		☐ Choking or Gaging on food	
☐ Slow eater		☐ Picky eater? Any texture?	
☐ Graze on Food throughout the day		☐ Won't try new food	
Quality of Feeding:			
☐ Excellent	☐ Average	☐ Difficult	☐ Limited	☐ Require Supplement

Solid Food Introduction:		
Product	Month	Response
Rice Cereal		☐ WNL ☐ Late Introduction ☐ struggle ☐ Aversive
Pureed		☐ WNL ☐ Late Introduction ☐ struggle ☐ Aversive
Level 3 (Lumpy Puree)		☐ WNL ☐ Late Introduction ☐ struggle ☐ Aversive
Finger Foods		☐ WNL ☐ Late Introduction ☐ struggle ☐ Aversive
Soft Mechanical Diet		☐ WNL ☐ Late Introduction ☐ struggle ☐ Aversive
Full Mechanical Diet		☐ WNL ☐ Late Introduction ☐ struggle ☐ Aversive

Current Diet Quality				
☐ Good Overall Eater	☐ Average	☐ Limited Eater	☐ Picky Eater	☐ Restricted
Can Swallow Pills	☐ Yes	☐ No		
Requires lots of fluids during mealtime:	☐ Yes	☐ No		

DENTAL HISTORY		
Name of the Dentist: _____ Address: _____		
Name of the Orthodontist: _____ Address: _____		
What was the reason for your last Dental Visit?		
Date of your last visit: _____ Date of your last cleaning		
How often do you brush your teeth?		
Do you have any dental Problem?	☐ Yes	☐ No
Are your teeth sensitive to hot, cold, sweets, biting or chewing?	☐ Yes	☐ No
Do you frequently get cold sores, blisters, or any other oral lesions?	☐ Yes	☐ No
Have you notice any mouth odors or bad taste?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No
Have you notice any loose teeth or change in your bit?	☐ Yes	☐ No
Do you clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Do you hold any foreign objects with your teeth? (pen, nails, pins, etc.)	☐ Yes	☐ No
Do you bite your lips, or cheek regularly?	☐ Yes	☐ No
Do you mouth breathe while awake or asleep?	☐ Yes	☐ No
Have you ever had problem with your jaw, joint, ear, or sides of face?	☐ Yes	☐ No
Does your bite feel uncomfortable or unusual?	☐ Yes	☐ No
Have you experienced difficulty chewing on either side of the mouth?	☐ Yes	☐ No
Does your jaw joints ever hurt or become tender when you chew or talk?	☐ Yes	☐ No
Do you have any tenderness in either jaw joint or your jaw muscles when you open wide?	☐ Yes	☐ No
Do you ever hear any clicks, pops, or grating sounds in your jaw joints?	☐ Yes	☐ No

Do you have frequent headaches?	☐ Yes	☐ No
Has your jaw ever locked open or closed?	☐ Yes	☐ No
Have you ever been treated for TMJ problem?	☐ Yes	☐ No
Primary teeth: ☐ Late Eruption ☐ Multiple Cavities ☐ Injuries ☐ Repairs	☐ Yes	☐ No
Permanent teeth: ☐ Late eruption ☐ Multiple Cavities ☐ Injuries ☐ Congenitally missing teeth ☐ Extraction	☐ Yes	☐ No
Have you ever had orthodontic treatment: ☐ Phase I ☐ Phase II ☐ Palatal Expander ☐ Head Gear ☐ Retainer Recurrent ortho	☐ Yes	☐ No
Have you ever had a bite plate or mouth guard?	☐ Yes	☐ No
☐ Periodontist Treatment ☐ Oral Surgery	☐ Yes	☐ No
Are you satisfied with the appearance of your smile?	☐ Yes	☐ No
If you could change your smile, what would you most like to change?		

Is there any additional parent/guardian information of which we need to be made aware? ☐ Yes ☐No
If yes, please explain: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature (Parent or Guardian if minor): _____ Date: _____

☐ I give my permission to take pictures and Videos.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____ Relationship with Patient: _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: By signing this form, I indicate I have had an opportunity to review a copy of Privacy Practices and will be provided a personal copy upon return request. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. By signing this form, I acknowledge that the above information is correct, and I understand the responsibility to inform the healthcare providers of Westchester MyoFunctional Therapy of any changes in my child's health or any medication as soon as possible.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected healthcare information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Contact Person: Hetal Sutaria or Nicole Tobon (914) 348-3486

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

Patient's/ Guardian's Name :_____ Patient's / Guardian's Signature:_____
Today's Date:_____