Text, whiteboard

Description automatically generated

**Medical Alert**

**Office Use**

**Orofacial**

**Myofunctional Assessment Form**

Your co-operation in completing this intake form is essential to providing you with the highest standard of care. Please answer the following as accurately as possible, as all information is strictly confidential and will remain with the office. If you have any questions or need clarification, please ask your treating hygienist or receptionist who is available to assist you with the completion of this form. Please accompany all children under the age of 18 to their dental appointments. You are not required to stay in office during the appointment but are needed to discuss and give consent prior to treatment and to discuss billing and next appointment scheduling at the end of the appointment. Underage dependants will be billed, and the fee’s will be the responsibility of the parents/guardians associated with their account. We will require the guardian’s signature and consent for insurance submissions. Parents/guardians are fully responsibility for their dependants’ account statement payments.

Client chart number (office use): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date form Completed:

Name: Date of Birth:

**Do you have/had any of the following: (check all that apply)**

Use of a pacifier?

Frequency of use:

When did they stop using it?

Digit sucking (finger/thumb)?

When did this stop?

Lip/Cheek biting

Teeth grinding

Clenching teeth Daytime Nighttime Both

Bite their nails/pens/pencils/blankies or other items?

Mouth breathing- Daytime or Nighttime Both

Difficulty breathing through both nostrils equally.

Chewing with mouth open

Difficulty swallowing food.

Difficulty swallowing pill medications.

Behavioral habits (please explain):

Frequent Hiccups

Bloating Acid Reflux Heart Burn

Orthodontic Correction (Braces)

Night Guard

Day time Splint

Dry Mouth

Difficulty with the pronunciation of specific words

Oral Lisp when speaking

Oral fatigue

Neck Tension

Shoulder tension

Popping or Clicking in the Jaw

Oral Piercings/Tattoos

Tonsils or adenoids removed.

Frequent Earaches or ear infections

Frequent Headaches/Migraines

Frequent Nosebleeds

Seasonal Allergies Mild Moderate Severe

Frequent Nasal congestion

Eye strain or fatigue, Eye Twitch,

Excessive blinking

Acute/Sudden Loss of muscle control

**Nutrition:**

How many servings per day:

Fruit:

Vegetables:

Meat/Alternative:

Dairy:

How many meals per day?

Would you categorize yourself as a picky eater?  Yes No

How many serving per day on average:

Carbonated beverages:

Hard candies:

Chewing Gum:

Junk food (chips, cookies, fruit snacks):

Natural and other sugars outside of main meals:

Please list any dietary restrictions:

Are you under the nutritional counsel of a physician, dietitian or naturopathic?

**Sleep:**

Average time asleep nightly without waking:

How many times do you wake per night on average?

Snores, Gasps for air, Talks in sleep

Tosses and turns a lot during sleep

Mouth breathing during sleep.

Frequent night terrors or vivid dreams

Occasionally Wets the bed

Cannot fall asleep without a comfort item (toy/pacifier/blanket etc.)

Falling asleep is a challenge

Experience daytime fatigue

Sleep with 2 or more pillows

Sleep in the same position every night

Sleep appliance (CPAP, BPAP, Oral Appliance, etc)

Sleep Study: Date:

Facial Pain when waking from sleep

Numb or tingling arms/hands/legs when waking from sleep