

**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