Orofacial Myofunctional Therapy Assessment

* Indicates required question

1. Name *

2. Date of Birth *

Example: January 7, 2019

3. Has anyone ever told you that you may be tongue-tied?

Mark only one oval.

- Yes
- No

4. As a baby were your breastfed or bottle fed?

Mark only one oval.

- Breast Fed
- Bottle Fed
- Unknown

5. Did you have difficulties feeding as an infant?

Mark only one oval.

- Yes
- No
- Maybe (unknown)

6. As a child did you have a history of ear infections?

Mark only one oval.

- Yes
- No

7. Have you ever had a finger or thumb sucking habit?

Mark only one oval.

- Yes
- No

8. As an infant, child, and/or adult, have you had any non-food allergies?

Mark only one oval.

- Yes
- No

9. What are you allergic to?

10. How do you manage your allergies?

11. Do you often feel your nose is blocked or congested?

Mark only one oval.

- ◯ Yes
- ◯ No

12. Do you have a history of other breathing problems?

Mark only one oval.

- ◯ Asthma
- ◯ Chronic nasal congestion
- ◯ Deviated Septum
- ◯ Turbinate reduction
- ◯ Sinus infections
- ◯ Nasal Polyps
- ◯ Airway Surgeries
- ◯ COPD
- ◯ Tuberculosis
- ◯ Other: _____

13. Do you notice you breathe more often through your mouth than your nose?

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Other: _____

14. Do you notice occasionally that your mouth is open at rest?

Mark only one oval.

- ◯ Yes
- ◯ No

15. Do you sleep with your mouth open or closed?

Mark only one oval.

- Open
- Closed
- Both
- Unsure

16. Where does the tip of your tongue rest in your mouth?

_____

17. Where does the back of your tongue rest in your mouth?

_____

18. Do you have any difficulties swallowing pills or certain foods?

Mark only one oval.

- Yes
- No

19. Do you have a hyperactive gag reflex?

Mark only one oval.

- Yes
- No
- Option 2

20. Do you chew with your mouth open?

Mark only one oval.

- Yes
- No

21. Do you feel like you need water to wash down your food when you eat?

Mark only one oval.

- Yes
- No

22. Do you have trouble swallowing or a history of choking?

Mark only one oval.

- Yes
- No

23. Have you had your tonsils removed or have you been told your tonsils are enlarged?

Mark only one oval.

- Yes
- No

24. Does it ever feel difficult to breathe and eat or chew food at the same time?

Mark only one oval.

- Yes
- No

25. Have you ever had food allergies or sensitivities?

Mark only one oval.

- Yes
- No

26. If you answered yes to allergies, which foods?

_____

27. As an infant, child, or adult, have you ever experienced any issues with digestion (digestion, stomach aches, bloating, burping, gas, acid reflux)?

Mark only one oval.

- Yes
- No

28. Have you ever had trouble with speech or participated in a speech therapy program?

Mark only one oval.

- Yes
- No

29. How long and what sounds?

_____

_____

_____

_____

_____

30. Do/did your parents notice any problems with clarity, mumbling, voice projection, or lack of facial movement?

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Other:

31. Do you have a history of tooth decay, gum disease, gum recession, or gum grafts?

Check all that apply.

- ☐ Decay
- ☐ Gum Disease
- ☐ Gum recession
- ☐ Gum grafts

32. Have you had orthodontic treatment in the past?

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Evaluated, but not treated

33. If you have had ortho, what was being treated? (check all that apply)

Check all that apply.

- ☐ Crowding
- ☐ Expansion
- ☐ Overbite
- ☐ Underbite
- ☐ Crossbite/Edge to Edge
- ☐ Head gear

34. Have you had any teeth extracted?

Mark only one oval.

- Premolars
- Wisdom teeth
- Other:

35. Have you noticed your teeth have shifted or changed?

Mark only one oval.

- Yes
- No

36. Do you snore?

Mark only one oval.

- Yes
- No

37. Average hours of sleep per night?

_____

38. Do you wake up feeling rested and refreshed?

Mark only one oval.

- Yes
- No

39. Are you tired during the day or do you feel chronically run down or fatigued?

Mark only one oval.

- Yes
- No

40. Have you been tested for Sleep Apnea?

Mark only one oval.

- Yes
- No

41. If yes, when and what was the diagnosis? (AHI: RDI: Oxygen Desaturation)

42. Do you have a C-Pap or dental sleep appliance?

Check all that apply.

	Yes	No
Cpap	☐	☐
Dental Sleep appliance	☐	☐
Do you wear it?	☐	☐

43. Have you ever been diagnosed with ADHD?

Mark only one oval.

- Yes
- No

44. Have you ever had symptoms of hyperactivity, trouble focusing, or behavioral issues?

Mark only one oval.

- Yes
- No

45. Did you or do you wet the bed frequently?

Mark only one oval.

- Yes
- No

46. Do you experience restless sleep with frequent tossing and turning?

Mark only one oval.

- Yes
- No

47. Other thoughts or comments

Thank you for taking the time to fill out the questionnaire. We will get back to you soon with your recommendations.

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