Patient's Name _____Birthday _____Age____ Today's Date _____

Medical issues: _____ Medications taking: _____

Allergies: _____ Previous clip or release of tongue? _____(date)

1. Has your child experienced any of the following issues? Please check or elaborate as needed.

Speech
___ Frustration with communication
___ Difficult to understand by parents
___ Difficult to understand by outsiders
___ % Percent of time you understand your child
___ Difficulty speaking fast
___Difficulty getting words out (groping for words)
___ Trouble with sounds (which?)_____
___ Speech delay (when?)_____
___ Stuttering
___ Speech harder to understand in long sentences
___ Speech therapy (how long)_____
___ Mumbling or speaking softly
___"Baby Talk"

Feeding
___ Frustration when eating
___ Difficulty transitioning to solid foods
___ Slow eater (doesn't finish meals)
___ Small appetite / Trouble gaining weight
___ Grazes on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky eater/ with textures (which?)_____
___ Choking or gagging on food
___ Spits out food
___Won't try new foods
___ Other:

Nursing or Bottle-Feeding Issues as a Baby
___ Painful nursing or shallow latch
___ Poor weight gain
___ Reflux or spitting up
___ Unable to hold pacifier
___ Milk dribbled out of mouth / messy eater
___ Poor Supply
___ Nipple shield required for nursing
___ Clicking or smacking noise when eating
___ Cried a lot / colic as baby
___ Other:

Sleep issues
___ Sleeps in strange positions
___ Sleeps restlessly (moves a lot)
___ Wakes easily or often
___ Wets the bed
___ Wakes up tired and not refreshed
___ Grinds teeth while sleeping
___ Sleeps with mouth open
___ Snores while sleeping (how often) _____
___ Gasps for air or stops breathing (sleep apnea)

Other related issues
___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Mouth open /mouth breathing during the day
___ Tonsils or adenoids removed previously
___ Ear tubes previously / lots of ear infections
___ Reflux (medicated or not)
___ Hyperactivity / Inattention
___ Constipation

Anything else we need to know:

Pediatrician _____

Speech Therapist _____

Who referred you to us? _____

Doctor's Signature _____