

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 _____

