PEDIATRIC
Feeding & Speech
SOLUTIONS

Adult Orofacial Myology Case History

Patient Name: _____ Sex: M/F Date of Birth: _____

Address: _____ City, State, Zip:_____

Home Phone: _____ Cell: _____

Email Address: _____

Do we have permission to use your email for updates and other communication? Yes No

Explain or list your concerns that brought you for an orofacial myology evaluation. _____
_____
_____

Who referred you or how did you find us? _____

Do you have any concerns regarding speech sounds, or speech clarity? Yes No If yes, please explain:_____
_____

Do you have any concerns regarding eating, biting, chewing, swallowing, messy/loud eating or long meals? Yes No?

Eating/Swallowing:	Yes	No	Not sure
Early feeding difficulty as a child? Or current?			
Reflux?			
Picky Eater?			
Avoid certain foods/textures?			
Do you drink a lot of liquid during meals?			

Did you have any prolonged sucking/biting habits as a child (pacifier, fingers, thumb), please explain _____

Medical Team

Name of Primary Care Physician: _____
Address: _____
Name of Dentist: _____
Address: _____
Name of Orthodontist: _____
Address: _____
Name of ENT: _____
Address: _____

Name of GI: _____
Address: _____
Name of Allergist: _____
Address: _____

Name(s) of other specialists or therapists: _____

Have you had braces? Yes No Did you have a palatal expander? Yes No
Do you have/ wear a retainer? Yes No

Medical Information

Please provide any significant medical history (i.e. illnesses, chronic conditions, medications, etc..): _____
_____
_____

Medical Diagnoses: _____

Do you have information regarding your tonsils or adenoids? (i.e. have they been removed, are they large, infections?) _____

Seasonal or food allergies? Yes No Ear infections? Yes No

Sinus infections? Yes No Drooling? Yes No

Do you sleep well? Yes No How many hours per night? _____

Snoring/ Sleep apnea? Yes No Do you use CPAP? Yes No

Are you a mouth breather? Yes No

Does your jaw feel "tired" during the day or when waking from sleep? Yes No

Any difficulties with your TMJ (i.e. clicking, popping, pain, difficulty opening mouth wide)?

Explain: _____

Habits: (circle) nail biting chewing on pen/pencil chewing on hair lip licking
sucking on tongue excessive gum chewing chewing inside of cheeks
resting/leaning face in your hand lip smacking lip biting

Please provide any additional information that may be related or helpful for this evaluation:
_____
_____
_____