

Patient's Name _____ Birthday _____ Age _____ Today's Date _____

Medical issues: _____ Medications taking: _____

Allergies: _____ Previous clip of tongue/lip? (when/where) _____

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 Talks" or uses baby voice

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
- Constipation
- Reflux (medicated or not)
- Affects family dynamics (can't eat out, etc.)

Nursing or Bottle-Feeding Issues as a Baby

- Painful nursing or shallow latch
- Poor weight gain
- Reflux or spitting up
- Gassy (tooted a lot) as baby
- Milk leaked out of mouth / messy eater
- Poor milk supply
- Nipple shield needed for nursing
- Clicking or smacking noise when eating
- Cried a lot / colic as baby
- Other: _____

Sleep Issues

- Sleeps in strange positions (bottom in air)
- Sleeps restlessly / kicks / 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)
- Night terrors (wakes screaming)

Other Related Issues

- Neck or shoulder tension or pain
- TMJ Pain, clicking, or popping
- Headaches or migraines
- Strong gag reflex
- Prolonged thumb sucking / pacifier use
- Mouth open / mouth breathing during the day
- Tonsils or adenoids removed previously
- Ear tubes previously / lots of ear infections
- Hyperactivity / Inattention
- Delayed walking or crawling (now or earlier)

Lip-Tie Issues

- Difficult or fights to brush top teeth
- Top teeth don't show when smiling
- Gap between two front teeth
- Cavities on front teeth
- Trouble eating from a spoon/ flips spoon over
- Trouble with B,P,M or W sounds
- Difficulty breathing through nose

Any Other Issues or Concerns?

Primary Care Provider _____ Chiropractor/PT/CST _____

Speech/Feeding Therapist _____ Other Therapist/Provider _____

Who referred you to us? _____

Doctor's Signature _____

