COMPREHENSIVE EVALUATION OF AIRWAY, ORAL, & FACIAL DEVELOPMENT FOR GROWING CHILDREN

PATIENT INFORMATION – PEDIATRIC INTAKE QUESTIONAIRE

Name: D.O.B: Current Age: Gender:

Parent/Guardians Name (if under 18):

Address: City: Postal Code:

Contact details

Home: Mobile:

Work: Fax:

Email:

Would you like to receive reminders for future appointments? ☐ YES ☐ NO

Preferred contact : ☐ email ☐ phone call

What is the reason(s) for visiting our practice?

- ☐ Sleep issues
- ☐ Mouth breathing
- ☐ Snoring/Noisy Breathing/Sleep Apnea
- ☐ Voice problems
- ☐ Referred by a dental/medical professional: ______________________
- ☐ Other reasons (please list): ______________________
- ☐ Tongue Tie evaluation
- ☐ Lip Tie evaluation
- ☐ Tonsil and adenoid evaluation
- ☐ Nasal blockage evaluation

Does the patient have any of the following health problems?

☐ Daytime tiredness	☐ Allergies	☐ Vision issues	☐ Down syndrome
☐ Difficulty concentrating	☐ Bed-wetting	☐ Speech impediment	☐ Seizures/epilepsy
☐ Restless sleep	☐ ADD/ADHD	☐ Chronic stutter/lisp	☐ Cleft lip/palate
☐ Often sick with colds	☐ Developmental delay	☐ Autism	☐ Heart murmur
☐ Asthma	☐ Hearing issues	☐ Cerebral Palsy	☐ Congenital heart defect

☐ Any other medical conditions that we should know about? ______________________

Has your child ever had surgery? ☐ YES ☐ NO if so, what for: ______________________

Has your child ever been hospitalized? ☐ YES ☐ NO if so, what for: ______________________

Does your child have any known allergens? ☐ YES ☐ NO if so, please list: ______________________

Does your child take any regular medications? ☐ YES ☐ NO if so, list medications: ______________________

How did you hear about our practice?

Your Child/Children's Dentist: City:

Your Child/Children's Doctor: City:

Your Child/Children's other health professional: City:

Would you like us to inform either professional of your treatment? ☐ YES ☐ NO ☐ ALL

Please answer Yes/No, or leave blank if unsure. Provide any additional information as desired.

1. When sleeping, does your child ever snore? ☐ YES ☐ NO ____________________
2. When sleeping, does our child ever appear to stop breathing? ☐ YES ☐ NO ____________________
3. When sleeping, does your child ever gasp or wake with a startle? ☐ YES ☐ NO ____________________
4. When sleeping, is your child's body ever in odd positions? ☐ YES ☐ NO ____________________
5. When sleeping, does your child have their head extended back? ☐ YES ☐ NO ____________________
6. When sleeping, does your child grind their teeth? ☐ YES ☐ NO ____________________
7. When sleeping, does your child sweat more than usual? ☐ YES ☐ NO ____________________
8. When sleeping, does your child breathe with their mouth open? ☐ YES ☐ NO ____________________
9. When sleeping, does your child leave drool on the pillow? ☐ YES ☐ NO ____________________
10. Does your child have difficulty getting to sleep? ☐ YES ☐ NO ____________________
11. Does your child difficulty staying asleep? ☐ YES ☐ NO ____________________
12. Does your child wake up then have trouble going back to sleep? ☐ YES ☐ NO ____________________
13. Does your child sleep lightly and are they easily roused? ☐ YES ☐ NO ____________________
14. Does your child wake up groggy and/or moody? ☐ YES ☐ NO ____________________
15. Does your child wake up with a headache? ☐ YES ☐ NO ____________________
16. Does your child appear lethargic or hyperactive during the day? ☐ YES ☐ NO ____________________
17. Does your child have nightmares? ☐ YES ☐ NO ____________________
18. Does your child sleepwalk or talk? ☐ YES ☐ NO ____________________
19. Does your child wet the bed? ☐ YES ☐ NO ____________________
20. Does your child toss and turn while asleep? ☐ YES ☐ NO ____________________
21. Does your child have problems with anxiety or behavioral issues? ☐ YES ☐ NO ____________________
22. Does your child have fidgety legs? ☐ YES ☐ NO ____________________
23. Does your child wake up in a tangle of bedclothes or on the wrong side of the bed? ☐ YES ☐ NO ____________________
24. Does your child chew with mouth open/messy eater? ☐ YES ☐ NO ____________________
25. Does your child exhibit thumb sucking or chewing on foreign objects (pencil, nail hair)? ☐ YES ☐ NO ____________________
26. How many hours of sleep does your child get, on average, in a 24-hour period including naps? (Circle)

    Less than 6   6-7   7-8   8-9   9-10   10-11   11-12   13-14   15-17

National Sleep Foundation Recommended Sleep Times

Toddlers (1-2 years)	11-14 hours
Preschoolers (3-5 years)	10-13 hours
School aged children (6-13 years)	9-11 hours
Teenagers (14-17 years)	8-9 hours

I have truthfully answered all of the above questions and agree to inform your practice of any changes in my child's medical history. In addition, I certify that I have custody and do authorize informed consent for the practice to perform a complete medical, dental, and/or myofunctional evaluation of the patient.

PARENT/ GUARDIAN NAME____________________SIGNATURE____________________DATE__________

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
___ 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
___ 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

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

Any Other Issues or Concerns?

Primary Care Provider _________________________________ Chiropractor/PT/CST_____________________________

Speech/Feeding Therapist _____________________________ Other Therapist/Provider__________________________

Who referred you to us? ______________________________ How far away do you live? _________________________

Doctor's Signature ___________________________________