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Myofunctional Therapy Intake

Name: _____ Date: _____

DOB: _____Allergies: _____

Diagnosed Health Conditions: _____

Primary Concerns: _____

Dentist: _____ Orthodontist: _____

MD/PCP: _____ Therapies: _____

Medications/Supplements: _____

Breathing:

- ☐ Mouth breathe (AM/PM/Both)
- ☐ Nasal breathe (AM/PM/Both)
- ☐ Breathing patterns: Shallow? Deep? Quick to be out of breath?

Teeth/Dental:

Any cavities? YES NO
Delayed getting teeth? Delayed losing teeth?: _____

Concerns presented by the dentist? _____

List dental and/or orthodontic treatments: _____

Do you get jaw pain? If so, when (AM/PM) and intensity: _____

Periodontal disease?	YES	NO
Relapse in bite?	YES	NO
Tongue Tie?	YES	NO
Lip Tie?	YES	NO
Clench	YES	NO

Grind YES NO

Current Eating Skills (please check any/all that apply):

- ☐ Messy eater
- ☐ Selective eater
- ☐ Fast eater
- ☐ Slow eater
- ☐ Fast eater
- ☐ Loud eater/tongue/lip smacking
- ☐ Open mouth
- ☐ Big bites
- ☐ Small bites
- ☐ Frequent dipper
- ☐ Needs a lot of liquids with intake
- ☐ Texture aversions
- ☐ Gag with eating
- ☐ Cough with eating
- ☐ Gassy following meals
- ☐ Other:

Gastro-Intestinal Discomfort:

Do you experience reflux? YES NO

Any issues or concerns with BM's? Constipation? Diarrhea? _____

Any food allergies or intolerances? _____

Habits (check any/all that apply):

- ☐ History of pacifier use? If so, how long?
- ☐ History of thumb sucking? If so, how long?
- ☐ Teeth clenching
- ☐ Teeth grinding (day, night)
- ☐ Chewing (shirts, pencils, fingernails, excess mouthing, ...)
- ☐ Lip biting/sucking
- ☐ Cheek biting
- ☐ Other: _____

Speech:

Any concerns with pronunciation? If yes, please explain: _____

_____

Medical:

- ☐ Frequent ear infections
- ☐ PE tubes
- ☐ Enlarged tonsils/Adenoids/Tonsil Stones
- ☐ Tonsils/Adenoids Removed
- ☐ Asthma/breathing issues (current or past)
- ☐ RSV/Pneumonia/Croup (current or past)
- ☐ Any hospitalizations? If yes, list: _____
- ☐ Headaches/migraines? Frequency: _____
- ☐ Jaw pain
- ☐ Body aches
- ☐ Heart condition
- ☐ Torticollis (current or past)
- ☐ Surgeries? If yes, list: _____
- ☐ Accidents/Injuries? _____
- ☐ Always seem sick
- ☐ Other: _____

Sleep:

How many hours of sleep do you get a night? _____

Do you wake well rested? Grouchy? _____

Do you fall asleep okay? _____

Toss/Turn?	YES	NO
Dark under eye circles?	YES	NO
Snore?	YES	NO
Loud breathing?	YES	NO
Dry mouth?	YES	NO
Wake during the night ?	YES	NO
Bad dreams/night terrors?	YES	NO
Sleep walking/talking?	YES	NO
Drool?	YES	NO
Concern for sleep apnea?	YES	NO
Concern for bladder control?	YES	NO
Sleep study?	YES	NO

-results: _____