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Myofunctional Therapy Intake

Name: _____ Date: _____

Caregiver(s): _____ DOB: _____

Allergies: _____

Diagnosed Health Conditions: _____

Primary Concerns: _____

Dentist: _____ Orthodontist: _____

MD/PCP: _____ Therapies: _____

Medications/Supplements: _____

Prenatal/Delivery:
Length of pregnancy: _____ Birth Weight_____

Any complications? _____

Other information: _____

Feeding:
Breastfed or bottlefed: _____

What did nursing or bottlefeeding look like? Difficulties? (Pain? Mastitis? Cluster feeding? Reflux? Noises?...)_____

_____

How long did your nurse/give bottles? _____

How was the transition from nursing/bottles to solids? Did you offer a puree or baby led weaning approach?

_____

Does anything stand out as being “off” with early feeding skills? _____

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

- ☐ Use utensils
- ☐ Selective eater
- ☐ Messy Eater
- ☐ Fast Eater
- ☐ Slow eater
- ☐ Fast Eater
- ☐ Loud eater/tongue/lip smacking
- ☐ Open mouth
- ☐ Big bites
- ☐ Small bites
- ☐ Frequent dipper
- ☐ Texture aversions
- ☐ Gag with eating
- ☐ Cough with eating
- ☐ Gassy following meals
- ☐ Other:

Gastro-Intestinal Discomfort:

Any reflux as a baby or currently? _____

Any history of being colicky as a baby?_____

Any gastro-intestinal discomfort now or as a baby?_____

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

Any food allergies or intolerances? _____

Habits (check any/all that apply):

- ☐ Pacifier use? If so, how long?
- ☐ Thumb sucking? If so, how long?
- ☐ Teeth clenching
- ☐ Teeth grinding (day, night)
- ☐ Chewing (shirts, pencils, fingernails, excess toy mouthing, ….)
- ☐ Other:

Milestones:

Any concern with speech/language development?_____

Did they crawl/sit/walk “on time”? _____

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

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
Tongue Tie?	YES	NO
Lip Tie?	YES	NO
Clench/Grind	YES	NO

Delayed getting teeth? Delayed losing teeth?: _____

Concerns presented by the dentist? _____

Sleep:

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

Do they wake well rested? Grouchy? _____

Do they 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
Bedwetting?	YES	NO

Other : Anything else you feel would be helpful for me to know? Questions I didn't ask?