PEDIATRIC
Feeding & Speech
SOLUTIONS

Orofacial Myology Case History

Child's/Patient Name: _____ Sex: M/F Date of Birth: _____

Mother: _____ Father:_____

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?

Feeding/Eating History:	Yes	No	Not Sure
Early feeding difficulty?			
Difficulty with breast feeding?			
Poor latch or difficulty staying on the breast?			
Nipple pain or other discomfort? Explain:			
Baby fatigue/ fall asleep at the breast/ fussy during feedings?			
Difficulty with bottle feeding?			
Reflux/ Colic?			
Weight gain concerns?			
Picky Eater?			
Avoids_ certain foods/textures?			
Notes:			
Takes a long time to eat/ chew?			
Drinks a lot during eating?			
Gag/choke/sensitive gag reflex?			
Messy/loud eater?			
Pulls lips in to clean or cleans with hand vs. licks lips clean?			
Drooling or food liquid loss while eating?			

Did you or do you have any sucking/biting habits (pacifier, fingers, thumb), please explain for

how long and if appropriate, when stopped? _____
_____

Medical Team

Name of Primary Care Physician/Pediatrician: _____
Address: _____
Name of Dentist: _____
Address: _____
Name of Orthodontist: _____
Address: _____
Name of ENT: _____
Address: _____
Name(s) of other specialists or therapists: _____

Medical Information

Please provide any significant birth and/or developmental history (i.e. full-term/ premature, healthy, frequent illnesses, etc..): _____
_____
_____

Medical Diagnoses: _____

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

Allergies? Yes No Ear infections? Yes No Sinus infections? Yes No

Drooling? Yes No List medications _____

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

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