

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

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: _____

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)

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.)

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)

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? _____ How far away do you live? _____

Doctor's Signature _____

