Child Name:_____ Date:_____

Person completing form: _____

(Name & Relationship)

Parent Assessment Form

Please answer the questions below to the best of your knowledge. This form will provide a basis for my exam and allow me to focus on the specific symptoms your child displays. A thorough exam of all your child's symptoms will be conducted on the day of the consultation.

1. Yes/No Has your child ever had a thumb or finger sucking habit?
2. Yes/No Has your child ever had allergies or food sensitivities?
3. Yes/No Do you notice that your child occasionally has his/her mouth open at rest?
4. Yes/No Has your child ever had troubles with speech, or been in a speech therapy program?
5. Yes/No Has anyone ever told you that your child may be tongue-tied?
6. Yes/No Did your child have any difficulties feeding as an infant?
7. Yes/No Has your child experienced any issues with digestion? (stomach aches, burping, gas, acid reflux, etc.)
8. Yes/No Do you notice that your child has a hyper-active gag reflex?
9. Yes/No Does your child have difficulty swallowing pills?
10. Yes/No Does it seem like your child is a messier eater than other kids? (chews with mouth open, drinks and chews at the same time, etc.)
11. Yes/No Has your child experienced any breathing issues or difficulties? (chronic congestion, asthma, etc.)
12. Yes/No Has your child had their tonsils removed, or have you been told the tonsils are enlarged?
13. Yes/No Do you notice that your child tends to breathe through his/her mouth more often than their nose?

Generally, if any of these questions can be answered "yes", your child is likely to have some myofunctional concerns. If you can answer "yes" to multiple questions, myofunctional therapy will be recommended.

Thank you very much for taking the time!

Additional Notes:

Check all that apply to the person being evaluated:

- ☐ ADHD
- ☐ Anxiety/depression
- ☐ Autism
- ☐ Bruxism (teeth grinding or clenching)
- ☐ Cerebral palsy
- ☐ Fatigue
- ☐ Poor quality sleep
- ☐ Mouth breathing during sleep
- ☐ Noisy breathing during sleep
- ☐ Snoring
- ☐ Sleep apnea
- ☐ TMJ Disorder
- ☐ Prior tongue tie release
- ☐ Prior orthodontics
- ☐ Prior jaw or maxillofacial surgery
- ☐ Prior myofunctional therapy
- ☐ Prior breathing therapy
- ☐ None of the above apply

Infant History:

1. Breastfed / Bottlefed How long? (months) _____
2. Pacifier use? YES/NO How long? (until age)_____

Headache History: (mild, mod, severe)

Location:_____ Frequency: _____ Pain:_____

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