Patient History & Assessment

Patient Name: _____ Date of Exam: _____

Parent/Sibling Names: _____Age/DOB: _____

Parent email (for zoom): _____

Latex allergy?: Yes No

Patient's Main Concern/Reason For Seeking Treatment:

Early Childhood:

Feeding: *Bottle Fed* *Breast fed* *Combo* *Not sure*

Difficulty feeding/latching

Birth: *Premature* *Long/difficult labor* *C-section*

Other: *Tongue-tied or lip tied as an infant* *Reflux as infant*

Messy/picky eater? Yes No

Oral aversions? Yes No

Open mouth chewing? Yes No

How quickly do you eat? Fast Moderate Slow

Have you ever noticed?
Air swallowing *Tongue thrust with swallowing* *Difficulty swallowing pills (if over age 12)* *Saliva pooling (daytime)* *Drool on pillow* *History of choking*
Frequent food or water "going down the wrong pipe" (aspiration)
Difficulty coordinating chewing and breathing *Hyperactive gag reflex*

Notes/Other:

Oral Habits:

Current oral habits: *Yes* *No*

Oral habits in past: *Yes* *No*

Thumb Sucking *Finger Sucking* *Nail Biting* *Prolonged Pacifier Use*
Sucking on clothing/hair/blanket/etc

Notes/Other:

Ears:

History of ear problems/infections? *Yes* *No*

Current ear problems/infections? *Yes* *No*

Tubes placed? *Yes* *No*

How many rounds of antibiotics?

Tinnitus *Vertigo* *Other symptoms*

Notes/Other:

Speech:

Has the patient been evaluated by a Speech Language Pathologist? *Yes* *No*

If they were treated, what was the focus of speech therapy?

Does the patient or parent believe that there are current speech concerns? *Yes* *No*

If so, what are they?

"S" sound/lisp *"R" or "L" problems* *General lack of clarity/mumbling*
Voice projection

Notes/Other:

Digestion:

Abdominal bloating/cramping *Burping* *Flatulence*

Acid reflux/Heartburn/GERD *Laryngopharyngeal Reflux (LPR)*

Irritable Bowel Syndrome (IBS) *Leaky gut*

Small Intestinal Bacterial Overgrowth (SIBO)

What is the frequency of these symptoms? (Daily, weekly, 3x/month, etc.)

Notes/Other:

Breathing History:

Allergies? *Yes (Seasonal, Dust, Pets/dander, Other)* *No*

Has the patient been formally tested for allergies? *Yes* *No*

What medications do they take for their allergies?

What else do they use to relieve symptoms? (saline nasal spray, Neti pot or rinsing, acupuncture, etc.)

Do they have nasal congestion that is not necessarily related to allergies? *Yes* *No*

Do they have a history of asthma or currently have asthma? *Yes* *No*

Do they take medication? *Yes* *No*

Notes/Other:

History of:

Septoplasty/rhinoplasty *Turbinate reduction* *Nasal polyps*

Nostril collapse (fast inhale) *Empty Nose Syndrome*

Sinus infections/pressure/headaches/pain *Chin implant*

Notes/Other :

Has the patient seen an ENT for an evaluation? *Yes* *No*

Has it been recommended to remove the tonsils and/or adenoids? *Yes* *No*

Allergic shiners/venous pooling? *Yes* *No*

Deviated septum? *Yes* *No*

Crease on bridge of nose? *Yes* *No*

Do you mouth breathe while awake? *Rarely/never* *Sometimes* *Often* *Almost always*

Do you mouth breathe while asleep? *Rarely/never* *Sometimes* *Often* *Almost always*

Notes/Other:

Head, Neck, and Jaw:

Pain or tension: *Neck* *Shoulders* *Migraines* *Headaches* *TMJ* *Facial*

Frequency:

Pain level (1-10):

Grinding: Yes No

Night guard/splint use or recommendation: Yes No

Other/Notes:

Posture and Bodywork:

Forward head posture *Rolled shoulders* *Slouching*

Has the patient ever worked with a professional on posture? (PT, OT, Yoga, Personal trainer): *Yes* *No*

Has the patient ever seen a chiropractor, PT, massage therapist, cranial osteopath, or any other type of body worker? *Yes* *No*

Other/Notes:

Sleep Disordered Breathing:

How many hours of sleep do you get on average?

Do you wake up feeling well rested? *Yes* *No*

Do you feel tired during the daytime? *Yes* *No*

Do you experience brain fog, forgetfulness, feeling "spaced out"? *Yes* *No*

Do you feel chronically fatigued or run down? *Yes* *No*

Do you experience insomnia? *Yes* *No*

Do you mouth breathe or heavy breathe at night? *Yes* *No*

How would you describe your sleep?

Interrupted *Restless* *Light sleeper* *Deep sleeper* *Soaked in sweat*
Wake up to use restroom regularly

Have you experienced or been diagnosed with any of the following conditions?

Snoring *Upper Airway Resistance Syndrome (UARS)*

Obstructive sleep apnea *Central sleep apnea*

Has a bed partner ever heard you stop breathing at night? *Yes* *No*

Has a dentist or doctor ever recommended a sleep study? *Yes* *No*

Have you ever had a sleep study? *Yes* *No*

If yes, what was your AHI, RDI, ODI?

Do you currently have a CPAP or MAD? *Yes* *No*

If yes, how often do you wear it?