



FAMILY SPEECH & THERAPY SERVICES

Oral Myofunctional Case History

Background Information

Name: _____ DOB: _____ Age: _____

Describe your concerns regarding your child: _____

Was this evaluation recommended by another professional? Yes _____ No _____

If yes, by who, and what concerns were shared with you? _____

Dentist's Name: _____ Last Dental Exam: _____

Has the patient been evaluated by an orthodontist? _____

Orthodontist's Name: _____ Last Exam: _____

If the patient as had orthodontic treatment, what kind and for how long? _____

Oral Habits

Does the patient have a history of a thumb _____ or finger _____ sucking habit? _____

If so, is the habit discontinued? _____

At what age was the sucking habit discontinued? _____

Did the patient use a pacifier? _____ If so, until what age? _____

Does the patient ever suck his/her tongue? _____ lips _____ other objects? _____

Does the patient have a fingernail biting habit? _____

If so, what age did it begin? _____

Speech

Do you have any speech concerns? _____

Has the patient had speech therapy? _____ If so, how long? _____

What agencies have provided speech therapy? _____

Does your child receive speech therapy services through the school district? Yes/ No
If yes, how often? _____

Name of child's therapist: _____ Phone number: _____

Sleep

Does the patient snore while sleeping? _____ If so, is the snoring loud? _____

If the patient snores, does it occur occasionally _____ or frequently? _____

Does the patient have a problem with bedwetting? _____

Does the patient have unusual sleeping positions? _____

If so, please describe: _____

Does the patient have difficulty awakening in the morning and/or appear disoriented or
groggy? _____

Does the patient appear sluggish or groggy during the day? _____

Is the patient frequently cranky/irritable? _____

School

School: _____ Grade: _____

Have the patient's teachers commented that the patient:

Has difficulty concentrating/focusing on subject matter? _____

Has difficulty sitting still? _____ Is disruptive? _____

Displays aggressive behavior? _____

Does your child have a history of neurological problems? _____

If so, please explain: _____



Please check yes or no for the following questions. After each question, please write in any comments that you feel would be helpful to us.

	YES	NO	COMMENTS
<u>Prenatal History:</u> Were there any illnesses, injuries, bleeding or any other difficulties before birth?			
Was the patient born prematurely or significantly past the due date? If yes, please give weeks and weight?			
Were there any complications with labor or delivery?			
Were there any feeding difficulties? Please specify			
Was the patient bottle fed?			
<u>Health History:</u> Does the patient experience frequent ear infections or fluid in the ears? Approximately how many or how often?			
Has the patient ever had PE tubes? If yes, are they still in? In what ear(s)?			
Has the patient ever had their hearing tested? If yes, when and what were the results.			
Does the patient have any allergies, sinusitis, or frequent congestion?			
Has the patient been diagnosed as having a deviated septum?			
Has the patient had tonsillitis? If so, how frequent? When was the last occurrence?			
Has the patient had tonsils removed? If so, when?			
Has the patient had adenoids removed? If so, when?			
Has the patient had strep throat? If so, how frequent? When was the last occurrence?			
Does the patient complain of frequent headaches?			
Does the patient take any medications?			
Does the patient have lips parted frequently?			