OroFacialTx, PLLC

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EVALUATION

NAME_____ AGE:_____ DOB: _____

1. Describe pregnancy:_____
2. Describe birth delivery (c-section, prolonged, epidural, induced, breeched, forceps, etc.)

   Explain: _____
3. Weight and condition at birth?_____
4. Breast fed? ☐ YES ☐ NO

   Explain:_____
5. Any problems during breast feeding?☐YES ☐ NO (latch, noisy, painful, reflux, vomiting)

   Explain:_____
6. History of lip or tongue tie? ☐ YES ☐ NO

   Explain:_____
7. History of colic? ☐ YES ☐ NO.

   Explain:_____
8. History of bottle feeding? ☐ YES ☐ NO

   Explain:_____
9. History of pacifier use? ☐ YES ☐ NO

How long? _____

10. Any developmental concerns (e.g., rolling/sitting/crawling/standing/walking/speaking/ fine motor)?

    Explain:_____
    _____

11. Any sensory issues? (noises, textures, tags) ☐ YES ☐ NO

    Explain:_____

12. Any sucking habits? (Select any that apply): ☐ FINGERS ☐ THUMB ☐ NAIL BITING ☐CLOTHING ☐ BLANKETS CHEEKS ☐ TONGUE ☐ PENCILS/PENS ☐ LIP BITING ☐LIP LICKING ☐ OBJECTS ☐ GUM

    Explain:_____

13. When were solid foods introduced?_____

Please indicate (check mark) if you have difficulty with any of the following while eating:

- ☐ Chewing Food
- ☐ Coughing
- ☐ Drooling
- ☐ Choking
- ☐ Gagging
- ☐ Other _____
- ☐ Holding cup/utensils
- ☐ Watery eyes when eating/drinking
- ☐ Moving food to the back of the mouth
- ☐ Clearing food/liquid from the mouth
- ☐ Drinking more than 1 cup of water during meals

14. Are you currently on a modified food and/or liquid diet? ☐ YES ☐ NO

    If yes, please explain. _____

15. Are there food/liquid textures that you avoid? ☐ YES ☐ NO

    If yes, please explain. _____

16. Do you currently wear dentures? ☐ YES ☐ NO Indicate ☐ Full or ☐ partial

17. Any digestive concerns (intolerances or allergies)? ☐ YES ☐ NO

Explain: _____

18. Select one of the following that applies to your oral intake 90% of the time:

☐ **RESTRICTIVE-** eats only certain foods- very limited food repertoire

(<30 foods with very strong preference and often excluding whole classes of food such as meats, fruits, & veggies)

☐ **PICKY-** refuses many foods but good repertoire of preferred food

(~30 foods consisting of easy, simple textures, purees and starchy foods with fewer proteins)

☐ **AVERAGE-** eats most foods with some preferences but willing to try new foods

(>30 foods with a better balance of foods across all class)

☐ **ADVENTUROUS-** eats a wide variety of foods with an appropriate amount

(>30 foods with a good balance of proteins, starches, fruits, and veggies)

19. Any vaccination concerns? ☐ YES ☐ NO

Explain:_____

20. Any surgeries, falls, or accidents? Explain:_____

Have you had or do you currently experience any of the following?

Condition	Yes	No	Age	Treatment	Condition	Yes	No	Age	Treatment
Allergies					Heart Problems				
Asthma					Immune Deficiency Syndrome				
Chicken Pox					Craniofacial Problems				
Meningitis					Convulsions/Seizures				
Muscular Disorder					Frequent Ear Infections				
Dental Problem					Pneumonia				
Nerve Disorder					Respiratory Infections				
Encephalitis					Tonsillitis				
Headaches					Vision Problems				
Thyroid Problems					Hashimoto's				
MTHFR					Ehlers Danlos Syndrome				
Head injuries					Other:				

21. If allergies were selected, please indicate type: (e.g. eggs, nuts, gluten free, grass, mold): _____

22. Do you take any medication(s)? ☐ YES ☐ NO
If yes, name, strength, frequency and for what condition.
_____

23. Have there been any negative reactions to medications? ☐ YES ☐ NO

_____

24. Any teeth grinding or clenching during the day? ☐ YES ☐ NO

Explain:_____

25. Is your mouth open or closed during the day?_____

23. Any TMJ Concerns?☐ YES ☐NO: ☐ CLICKING ☐ POPPING ☐PAIN ☐ RINGING IN EARS

Have you had or do you currently experience any of the following?

Condition	Yes	No	Age	Treatment	Condition	Yes	No	Age	Treatment
Appliance					Mouth sores				
Blisters					Oral thrush				
Cavities					Orthodontia				
Early/late tooth loss					Tooth erosion				
Gum disease (gingivitis)					Thumb/finger sucking				
Halitosis (bad breath)					Other Noxious Habits				
Missing teeth					Other:				
Mouth guard									

28. How do you breathe? ☐MOUTH ☐NASAL ☐ CONGESTED ☐ WITH DIFFICULTY

29. What position do you sleep? ☐ RIGHT SIDE ☐ LEFT SIDE ☐STOMACH ☐ BACK

30. What is the quality of your sleep? ☐ GOOD ☐ RESTLESS ☐ INTERRUPTED
☐DIFFICULTY FALLING ASLEEP ☐ DIFFICULTY WAKING UP

35. How often do you wake in the middle of the night?_____

36. How do you feel when you wake up the next day?

☐ RESTED ☐ TIRED ☐ UNFOCUSED ☐ RESTLESS

37. Do you have night terrors or bedwetting? ☐ YES ☐NO

How often?_____

38. Do you grind your teeth while sleeping? ☐YES ☐ NO

39. Do you snore? ☐ YES ☐NO

40. Breath holding or irregular breathing while sleeping? ☐YES ☐NO

41. Do you have any behavior concerns?_____

42. Do you have any social concerns?_____

43. Do you have learning concerns?_____

44. Do you have a history of Orthodonitcs? ☐ YES ☐NO

Orthodontist Name: _____

When?_____