72 PArk st Dental

Strengthen * Breathe * Sleep
Health Intake Form

Date: _____

Name:_____ Age:_____ Date of Birth: _____

Address: _____Town:_____Zipcode:_____

Phone: _____

E-Mail:_____ How Did You Hear About Us?:_____

Birth History

Natural or Cesarean:_____

Complications (Please add any details to the child's birth history):

_____

Infant Feeding History (breast, bottle, or mixed. Please let us know if the child had any difficulties feeding):

_____

Non-Nutritive Sucking (Duration, Intensity, Frequency): _____

☐ Thumb ☐ Finger ☐ Blanket ☐ Clothing ☐ Cheek ☐ Tongue ☐ Pen ☐ Nail Biting

Milestones Age Achieved:

Crawling_____ Walking_____ Talking_____ Eye/Hand_____

Breathing: ☐ NASAL ☐ MOUTH BREATHING ☐ COMBINATION Asthma:_____

Allergies:_____

Tonsils/Adenoids (Issues or Removed):_____ Sinus Issues:_____

History of Sore Throats/Colds:_____

Ears Issues and History

Ache_____ Fluid:_____ Ringing:_____ Tubes Placed:_____

Headaches History

Where:_____ Pain:_____ Frequency:_____ Triggers:_____

TMJD-Temporomandibular Joint Disorder

Where:_____ Pain:_____ Sounds:_____

Neck/Shoulder Pain:_____ Natural Posture:_____ Clenching/Bruxism:_____

Swallow

History of Gag Reflex:_____ Problem Swallowing Pills:_____

Drooling During The Day or While Sleeping:_____ Frequent Dry Lips:_____

Any trauma or Injury to the head (use of a forceps at birth, concussion)_____

_____

Sleep

Posture (Side, Back, or Stomach): _____

Mouth: ☐ Opened ☐ Closed ☐ Mixed

Snoring:_____

Sleep Hygiene/Habits:_____

Eating

☐ Hiccups_____ ☐ Gas_____ ☐ Digestion_____ ☐ Gagging _____

☐ Food Aversions/Allergies:_____

Typical Breakfast/Lunch/Dinner:_____

Health Concerns

Health Conditions:_____

Medications:_____

Surgeries/Injuries:_____

Hobbies:_____

Signature:_____ Date:_____

Activity	Yes/No	Notes
While sleeping, does your child have trouble breathing or struggle to breath?	[ ] Yes [ ] No	
While sleeping, does your child have "heavy" or loud breathing? Snore regularly? Snore loudly?	[ ] Yes [ ] No	
While sleeping, does your child snore more than half the time?	[ ] Yes [ ] No	
While sleeping, does your child appear to be a restless sleeper and/or kick during sleep?	[ ] Yes [ ] No	
While sleeping, does your child have nightmares and/or scream in their sleep?	[ ] Yes [ ] No	
While sleeping, does your child grind their teeth during sleep?	[ ] Yes [ ] No	
While sleeping, does your child sleepwalk?	[ ] Yes [ ] No	
While sleeping, does your child occasionally wet the bed?	[ ] Yes [ ] No	
Upon awakening, does your child have a dry mouth in the morning?	[ ] Yes [ ] No	
Does your child tend to breathe through the mouth during the day?	[ ] Yes [ ] No	
Does your child wake up feeling un-refreshed in the morning?	[ ] Yes [ ] No	
Does your child have a problem with sleepiness during the day?	[ ] Yes [ ] No	
Does your child have trouble getting going in the morning?	[ ] Yes [ ] No	
Does your child wake up with headaches in the morning?	[ ] Yes [ ] No	
We have noticed that our child has difficulty organizing tasks and/or is easily distracted by extraneous stimuli.	[ ] Yes [ ] No	
We have noticed that our child fidgets with hands or feet or squirms in seat.	[ ] Yes [ ] No	
Has a teacher or other supervisor comment that your child appears sleepy during the day?	[ ] Yes [ ] No	
We have noticed that our child interrupts or intrudes on others (e.g. butts into conversations or games)	[ ] Yes [ ] No	
Has your child been diagnosed with ADD or ADHD	[ ] Yes [ ] No	
We have noticed that our child does not seem to listen when spoklen to directly.	[ ] Yes [ ] No	
Did your child stop growing at a normal rate at any time since birth?	[ ] Yes [ ] No	
Is your child overweight?	[ ] Yes [ ] No	
Does your child's teeth seem crooked or misaligned?	[ ] Yes [ ] No	
Does your child have allergies or frequent colds?	[ ] Yes [ ] No	
Does your child have difficulty with pronunciation?	[ ] Yes [ ] No	

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
___ Tonsils or adenoids removed previously
___ Difficulty breathing through nose
___ Ear tubes previously / lots of ear infection
___ Hyperactivity / Inattention

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
___ 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)

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 _____