Chris Zombek BSDH, COM®

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**Please email filled out within 2 to 3 business days so you may receive a call**

**Child Health form under 14**

First Name

|  |
| --- |
|  |

Last Name

|  |
| --- |
|  |

Address of Patient

|  |
| --- |
|  |

Address of Parent or Guardian

|  |
| --- |
|  |

Parent or Guardian First and Last name

|  |
| --- |
|  |

Address

|  |
| --- |
|  |

Phone: Best number to reach in case issue with existing appointment or appointment coming up:

Work for Parent:

Cell:

Home:

Email:

Age of child:

DOB:

Who should we thank for referral?

**Please print name, address, phone#**

Physician?

Orthodontist?

Dentist?

ENT?

Allergist?

Speech Pathologist?

 History of Speech pathology treatment?

 Does your child have any problems pronouncing sounds?

 Which letters?

School child attends?

**Childs interest (hobbies, Sports, Instruments)?**

Date of last medical exam?

Are they under the care of a physician? What for?

**Childs medications?**

Date of the last dental exam?

Give reason for visit today?

Have they been hospitalized in the past 5 years?

**Any allergies to meds, foods, or anything else? Have they been tested?**

Past and present problems with tonsils or adenoids?

Injury to head, neck, back, or pelvic?

Does your child drool during the day?

Yes

No

Don’t know

Have you noticed that your child has difficulty breathing during day or with a lot of effort with sports ?

Yes

No

Don’t know

Does your child easily fatigue after exercising?

Yes

No

Don’t know

Do your child keep their mouth open while watching TV or using the computer?

Yes

No Don’t know

Does your child demonstrate poor posture while sitting or standing?

Yes Don’t know

NO

Does your child eat with their lips open?

Yes

No

Don’t know

Is your child a messy eater?

Yes  Don’t know

No

Did your child nurse? Were their feeding difficulties?

Yes

No

Are there any digestive problems?

Nursed? How Long Weak sucking?

 Bottle use? How Long? Age weaned?

Pacifier on other? How Long?

Have a sippy cup? How Long?

Gastro-intestinal issues? Reflux?

Any Serious illness?

Yes

No

If yes what?

Ear infection history? Tubes?

Yes No

Loss hearing?

Does your child easily catch colds?

Yes

No

Strep Throat

Sore Throat

Nasal obstruction:

\_\_\_\_\_ Sinus infection \_\_\_\_ Deviated Septum

\_\_\_\_\_ Sinus pain \_\_\_\_ Asthma

Do they have a history of the following?

Thumb sucking \_\_\_\_ Blanket sucking \_\_\_\_ Lip sucking

Finger sucking \_\_\_\_ Hair chewing \_\_\_\_ Sleeps with blanket

Tongue Sucking \_\_\_\_ Lip Licking or biting \_\_\_\_ Tried to eliminate habit

Nail biting \_\_\_\_ Pencil chewing

Does your child have difficulty pronouncing sounds?

Yes

No

Which sounds?

Is the child?

Right Handed

Left Handed

Has your child ever visited to an ENT?

If so what for?

Does your child grind or clench their teeth during the day or at night?

Yes

No

If Yes:

Day Night Day and Night

**Sleep specific questions:**

While sleeping does your child

Snore Always Sometimes

Break or pause while breathing

Sleep with their mouth open

Sleep on their stomach

Demonstrate restless or agitated sleep

Demonstrate abnormal head postures (hyper-extend)

 Breath heavy at night?

 Yes No

Does your child occasionally wet the bed, sleepwalk, or have night terrors?

 Yes No Sometimes Don’t know

Does your child have a hard time waking up in the morning?

 Yes No

Does your child have dry mouth in the morning or bad breath?

 Yes No

Does your child have headaches in the morning?

 Yes No

Does your child have on going sleepiness throughout the day?

 Yes No

Does your child’s teacher report behavior issues, sleepiness at school?

 Yes No

Does your child have any growth issues?

 Yes No

Does your child have attention deficit problem or listening problem?

Explain?

Does your child fidget with hands, squirm or other objects?

 Yes No

Does your child often act out?

 Yes No Explain?

Is your child’s pillow wet in the morning?

Yes Don’t know

No

Who first noticed orofacial myology problem and when?

What do you want to see achieved? What are your expectations?

Has child/teenager been treated for or had any of the following below?

Heart Surgery Blood Transfusions

Heart Disorder Anemia

Myocardial Infarction Hemophilia

Chest Pain ( Angina Pectoris) Neurological disorders

Shortness of Breath Epilepsy or Seizures

Congenital Heart Disease ADD/ ADHD

Heart Murmur Stroke

Mitral Valve Prolapse  Bell’s Palsy

High/Low Blood pressure Cerebral Palsy

Artificial Heart Valve Down Syndrome

Cancer Artificial Joint

Hepatitis Kidney Troubles

Venereal Disease  Psychological Care

Herpes  Alzheimer’s Disease

A.I.D.S  TMJ Pain

HIV Positive  Headaches

Cold Sores/Fever Blisters Tinnitus

Blood Disorders  Drug Dependency

I understand the above information is necessary to provide me with Orofacial Myofunctional Therapy in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the therapist of any change in my health or medication.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_