Child Questionnaire

Patient Name:_____Birth date:_____Age:_____Today's Date:_____

Medical Problems? □ Yes □ No If yes, explain:_____

Medications:_____Allergies:_____

Bleeding Disorder? □ Yes □ No Connective Tissue Disorder? □ Yes □ No

Previous clip or release of tongue-tie? □ Yes □ No If yes, date:_____

1. Has your child experienced any of the following issues? (check all that apply)

Speech

□ Frustration with communication
□ Difficult to understand by parents
□ Difficult to understand by others
□ Difficulty speaking fast
□ Difficulty getting words out
□ Baby talk
□ Trouble with sounds (which?)_____
□ Speech delay
□ Stuttering
□ Speech harder to understand in long sentences
□ Speech therapy? If yes, how long?_____
□ Mumbling or speaking softly

What percent of the time do you understand your child?_____%

Feeding

□ Frustration when eating
□ Difficulty transitioning to solid foods
□ Slow eater (doesn't finish meals)
□ Grazes on food throughout the day
□ Packing food in cheeks like a chipmunk
□ Picky with textures (which?)_____
□ Choking or gagging on food
□ Spits out food
□ Other:_____

Nursing or Bottle-Feeding Issues as a Baby

□ Painful nursing
□ Shallow latch
□ Poor weight-gain
□ Reflux or spitting up
□ Unable to hold pacifier
□ Milk dribbling out of mouth
□ Poor supply
□ Nipple shield required while nursing
□ Clicking or smacking noise when eating
□ Other:_____

Sleep Issues

□ Sleeps in strange position
□ Kicks and flails around at night
□ Wakes easily or often
□ Wets the bed
□ Wakes up tired and not refreshed
□ Grinds teeth while sleeping
□ Sleeps with mouth open
□ Snores while sleeping? If yes, how often?_____
□ Gasps for air or stops breathing (sleep apnea)

Other Related Issues

□ Neck or shoulder pain or tension
□ Headaches or migraines
□ Mouth open / mouth breathing during the day
□ Ear tubes previously
□ ADHD / ADD
□ TMJ pain, clicking, or popping
□ Strong gag reflex
□ Tonsils or adenoids previously removed
□ Reflux? Medication?_____
□ Constipation

Is there anything else we should know?

_____

_____

Pediatrician:_____ Phone number:_____

Speech Therapist:_____ Phone number:_____

Who referred you to us?_____

Doctor's Signature_____ Date:_____