

OROFACIAL MYOLOGY (TONGUE THRUST) HISTORY

NAME: _____ AGE: _____ DATE OF BIRTH: _____

DENTIST: _____ REFERRED BY: _____ DATE: _____

GENERAL HEALTH:

- Physical Problems: _____
- Allergies, Ear, Nose, Throat Problems: _____
- Medications: _____
- Orthodontia: _____

EATING HABITS:

- Fast or Slow? _____
- Difficulty biting? _____
- Drinks excessively? _____
- Chews with mouth open? _____
- Difficulty swallowing pills? _____

INFANT FEEDING:

- Breast? _____ Duration: _____
- Bottle? _____ Duration? _____
- Type of bottle? _____

EMOTIONAL DEVELOPMENT:

- Motivational level of child: _____
- Maturity: _____

SUBCONSCIOUS HABITS:

Does your child or did he/she ever engage in the following? If so, when, and for how long?

	<u>Previously</u>	<u>Presently</u>	<u>Length of time</u>
Finger or thumb sucking	_____	_____	_____
Lip sucking	_____	_____	_____
Blanket sucking	_____	_____	_____
Chewing on pencils or other foreign objects	_____	_____	_____
Extra facial movements while eating	_____	_____	_____
Grinding of teeth	_____	_____	_____
Fingernail biting	_____	_____	_____
Messy Eater	_____	_____	_____
Pacifier use	_____	_____	_____
Mouth breathing	_____	_____	_____

FAMILY HISTORY:

- Number of siblings & their ages: _____
- Others in family with similar problems? _____

SCHOOL STATUS:

- Grade level: _____ School: _____
- Special learning problems: _____

SPEECH THERAPY:

- Where: _____
- When: _____
- Progress: _____
- Present Therapist: _____
- Worked on: _____
- Others in family who had speech therapy: _____