Kalamazoo Speech Associates
Center for Myofunctional and Speech-Language Therapy

OROFACIAL MYOLOGY EVALUATION INTAKE FORM

We thank you in advance for completing this form as accurately and thoroughly as possible.
The answers to these questions directly contribute to developing the proper treatment plan for your child.

CLIENT INFORMATION

Client Full Name: ______________________________

Date of Birth: ________________ Age: ________________ Grade: ________________

Address: ______________________________

City: ______________________ State: _____ Zip Code: _________

Referred By: ______________________________

Doctor/Pediatrician: ______________________________

Doctor/Pediatrician Address: ______________________________

Phone Number: ______________________________

PARENT / GUARDIAN INFORMATION

Parent/Guardian Name (1): ______________________________

Employer Name & Address: ______________________________

Preferred Phone Number: ______________________ ☐ Home ☐ Mobile

Secondary Phone Number: ______________________ ☐ Home ☐ Mobile

Email: ______________________________

Parent/Guardian Name (2): ______________________________

Employer Name & Address: ______________________________

Preferred Phone Number: ______________________ ☐ Home ☐ Mobile

Secondary Phone Number: ______________________ ☐ Home ☐ Mobile

Email: ______________________________

SIBLING INFORMATION (if applicable)

Full Name ______________________ Age ______________

Full Name ______________________ Age ______________

Full Name ______________________ Age ______________

Full Name ______________________ Age ______________

Please indicate if any siblings or parents have had a history of speech, hearing, and/or myofunctional (tongue thrust, TMD) problems?

____

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____

BIRTH HISTORY

Age of parent(s) at child's birth:

Parent 1: ____ Parent 2: ____

Pregnancy:

☐ Normal

☐ Difficulties

Specify Difficulties (if any):

____
____
____
____

Birth:

Weight: ____ lbs.

Length: ____ inches

Order of birth: ____

☐ Required Oxygen

☐ Jaundiced

☐ Light Treatment

☐ Other: ____
____
____

Labor & Delivery:

Length of Hard Labor: ____ hrs.

☐ Premature ____ # days

☐ No Complications

☐ Late ____ # days

☐ Instruments Used ___________

☐ Caesarean Section

☐ Breech

Difficulties with:

☐ Health

☐ Feeding

☐ Sleeping

Please explain:

____
____
____
____

Feeding:

☐ Breast Fed: ____ # months

☐ Bottle Fed: ____ # months

Infant feeding difficulties, please explain:

____
____
____
____

MEDICAL HISTORY

Date of last physical examination: _________________

Does your child have a chronic medical condition? ☐ Yes ☐ No

Please Explain: ____

Has your child ever been a patient in a hospital or had any outpatient procedures? ☐ Yes ☐ No

Please Explain: ____
____
____

Is your child allergic to any foods or medications? ☐ Yes ☐ No

Please Explain: ____
____
____

Does your child have any other allergies? ☐ Yes ☐ No

Please Explain: ____
____
____

Does your child take any medication? ☐ Yes ☐ No

Please Explain: ____

____

____

DENTAL HISTORY

Date of last dental examination _______________

Has your child ever had any of the following dental problems?

☐ Toothache (☐ frequent ☐occasional)
☐ Teeth sensitive to sweets
☐ Teeth sensitive to hot or cold
☐ Teeth banged or chipped
☐ Crooked teeth
☐ Discolored teeth
☐ Cavities

Does your child have any other dental problems other than those listed above? ☐ Yes ☐ No

Please Explain: ____

____

____

Does your child see an orthodontist? ☐ Yes ☐ No

Orthodontist Address: ____

Phone Number: ____

Does your child suck their thumb or finger(s)? ☐ Yes ☐ No

Does your child have any other oral habits? ☐ Yes ☐ No

Please Explain: ____

____

____

During quiet activities, such as reading or screen time, is your child's lips more likely to be? ☐ Together ☐ Apart

Parent Signature ____ Date _____________

Printed Name ____