Milwaukee Myo
Mequon Speech and Learning Connection

Orofacial Myology Case History

Name: _____ DOB: _____ Age: _____

Parent/Legal Guardian: _____

Referral Source: _____ Reason for Referral: _____

Date of Evaluation: _____ Evaluating Therapist: _____

Will you be submitting insurance? Y / N

(*Please Note: We do not bill the insurance company directly, but will provide you with completed forms to submit. Also, you may not submit insurance unless you have a full Evaluation with written report*).

If yes, please provide:

Name of Insured:_____ DOB of Insured: _____

SS# of Insured: _____ Employer: _____

Insurance Company: _____ Policy ID #:_____

For Children Only:

Nickname: _____ Siblings (include names/ages): _____

_____

What is child's primary language? _____ What languages does child speak? _____

School: _____ Grade: _____

Teacher(s): _____

How is child doing academically (or pre-academically)? _____

Do you have any specific concerns regarding school? _____

Does child receive any special services in school? If yes, please describe:_____

_____

Does child receive any special services outside of school? If yes, please describe: _____

_____

How does child interact with others (e.g., shy, aggressive, uncooperative, etc.)? _____

_____

Is child aware of reason for referral: _____

Please describe child's response to sound and whether he/she is sensitive or underactive to sounds: _____

_____

How much screen time (TV and iPad) does child get daily during the week? _____On weekends?_____

Pediatrician's Name/Address/Phone: _____

_____

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem:

_____

Please provide approximate age at which child began the following:

Crawl ____ Sit ____ Walk ____ Dress Self: ____ Use Toilet: ____ Use Utensils: ____

Use Single Words: ____ Combine Words: ____ Use Simple Questions: ____ Engage in Conversation: ____

Little to No Babbling ____ Regression of Speech & Language Skills: ____

Mother's Name: _____ Occupation: _____

Phone: (____)_____/H _____ /W_____/C

Father's Name: _____ Occupation: _____

Phone: (____)_____/H _____ /W_____/C

Address: _____

Street *City* *State* *Zip*

Does child live with both parents? __Y __N If No, who has custody? _____

What is the address of the other home:

_____

For Adults Only:

Phone: (____)_____/H _____ /W_____/C

Address: _____

Occupation: _____ Email: _____

Living Situation: __Single __Partner __Married __Divorced __Widowed

Children (*please provide names & ages*): _____

Highest grade completed/Diploma/Degree: _____

Was this evaluation recommended by another professional? __Y __N

If yes, by whom, and what concerns were shared with you? _____

_____

For All *(info pertaining to Prenatal & Birth History as well as Feeding, Pacifier & Sippy Cup History is important for Adults to complete)*

Describe your concerns/reasons for referral: _____

_____

What are your main goals for therapy? What do you hope to accomplish? _____

_____

When was the problem first noticed? _____

_____

Have You/the Child been seen by any other specialists (physicians, physical therapists, occupational therapists, special ed teachers)? If yes, indicate name, phone number, specialty, date seen, and the specialist's conclusions:

_____

Doctor's Name/Address/Phone: _____

_____

Have You/the Child ever been given a medical diagnosis? If yes, what?

_____

Dentist's Name: _____ Last Exam: _____

Have You/the Child ever been evaluated by an Orthodontist? __Y __N Last Exam _____

Orthodontist's Name: _____ _____

If You/the Child have had Orthodontic treatment, what kind/how long?

_____

Any Orthodontic relapse? __Y __N

Please list any current orthodontic appliances you wear (including sleep appliances): _____

_____

Prenatal History

__ WNL* *(within normal limits)*

__Drug Exposure __Alcohol Exposure

__Smoking __Complications __Preeclampsia

Birth History

__WNL* (born around 40 weeks) _____ Birth Weight

__Early Delivery Number of weeks _____

__Extensive Labor __Premature Labor __C-section

__Forceps/Vacuum __ Induction __Complications

__Head First __Breech

General condition at birth: _____

Mother's general health during pregnancy (illnesses, accidents, medication, etc.): _____

_____

Were there any unusual conditions that may have affected the pregnancy or birth (include any special precautions taken such as bed rest, Jaundice, etc.?_____

_____

Early Feeding Methods

__Breastfed

__Attempted Breastfeeding

__Bottle Fed

__Both

__NG Tube

Duration____

Comments:

Difficulties with Early Feeding Years

__Excessive Burping __Excessive Spit-up __Clicking

__Projectile Vomiting __GERD __Mastitis

__Pulled off Nipple __Fatigued Easily __Pain When Nursing

__Tongue Tie __Lip Tie __Cracked/Bleeding Nipples

__Choking __Gagging

__Excessive Drooling __Allergies/Sensitivities

Comments:

Pacifier Usage: __Y __N Type: _____ Discontinued Usage Age: _____

Sippy Cup Initiation Age: _____ Sippy Cup Type: __Hard-Protruding Spout __Open/Perforated Spout __Negative Pressure Suction Valve Exclusively Used Open Cup at Age_____

Comments:

General Medical History

__Recurrent Upper Respiratory Infection __Recurrent Sinus Infections __Recurrent Strep Throat

__Report/History of Enlarges Tonsils __Deviated Septum __Tinnitus

__Tonsillectomy: Age___ __Recurrent Ear Infections __Myringotomy (ear tubes)

__Removal of Adenoids: Age___ __Asthma __Diabetes

__Cancer __Seizures __High Fever

__Constipation __Heart Issues __Autism

__Developmental Delay __Surgeries_____

Other/Comments: _____

Medical/Developmental Conditions/Surgeries:

Rx Medications/Inhalers: _____

Supplements/Oils/Herbs: _____

Headaches	Pain Disorders		Seasonal/Environmental Allergies
__Periodically	__Joint/Arthritis	__Rheum. Arthritis	__None Reported
__Chronic	__Jaw/TMD Pain	__Fibromyalgia	__Spring __Fall __Year Round
__Migraines	__Cervical Disorder	__Lumbar Disorder	__Asthma
Related to:	__Muscular Pain	__Tri. Neuralgia	__Mild __Moderate __Severe
	Other:		__Controlled w/OTC __ w/Rx
			Other control methods:

Have there been any negative reactions to medications? If yes, identify:_____

_____

Comments:

Sleep

When do You/the Child go to bed? _____ Wake up? _____ Snore? __Y __ N Restless Sleeper? __Y __ N

Clenching/Grinding in sleep? __Y __N Do You/the Child get up in the middle of the night? __Y __N

Do You/the Child's sleep schedule stay consistent even on weekends? __Y __N

Do You/the Child have any bedwetting issues/concerns?_____

Are there any sleep issues/concerns?_____

_____

General Dental History

__No Dental Treatment to Date __Cavities __Primary Teeth Extracted (Baby Teeth)

__Permanent Teeth Extracted (Adult Teeth) __ Wisdom Teeth

Other:

Orthodontia History

__No Orthodontic Treatment to Date
__Orthodontic Exam Only
__Phase I Orthodontic Treatment
__Orthodontic Appliance Therapy (previous/current)
__Previous Palatal Expansion
__Current Palatal Expansion
__Palatal Arch Retainer
__Head Gear
__Currently in Full Bands
__Completed Orthodontics
__Reports Orthodontics Relapse
__Retainers
__Splint Therapy
__TMD Therapy Appliances
__Invisalign (previous/current)
Other:

Additional Dental Comments:

Speech Development

__Reported WNL* __Delayed __Speech Errors __Mumbles __Early Language Delay

__History of Speech Therapy __Current Speech Therapy __Further Speech/Language Eval Required

Are there any other speech, language, myofunctional, or hearing problems in your family? If yes, please describe:

_____

Speech Therapy

__Reported No Speech Therapy to Address Sound Errors

__Reported Speech Therapy in Early Developmental Years

__Reported Speech Therapy in School Years __Current __Previous __Resolved

__Reported Speech Therapy in Private Practice __Current __Previous __Resolved

__IEP __504 __Other

Have You/the Child been seen by any other speech-language specialists? If yes:

Who/When/Conclusion: _____

Comments:

Fine Motor Development

__WNL* *(within normal limits)*
__ Delayed

Gross Motor Development

__WNL*
__Delayed

Reed Instruments

__Does Not Play Reed Instruments
__Limited Playing of Reed Instruments
__Plays with Passion
__Reports Structural Changes
__Orthodontist is Aware

Brass Instruments

__Does Not Play Brass Instrument
__Limited Playing of Brass Instruments
__Plays with Passion
__ Reports Structural Changes
__Orthodontist is Aware

Sports/Activities/Hobbies:

Potential for Therapy Home Care Compliance

__Self Starter __Capable of Following Directions __Will need Parent/Caretaker Assistance

__Home Care Will Be Limited

Sports Bottle Usage

__Open Valve __Excessive Usage

__Straw __Moderate Usage

__Camel-Back type (w/bite & suck) __Occasional Usage

__Protruding Spout

Generalized Complaints from:

Drinking

Chewing

Swallowing

Throat

Stomach

Reported Food Aversions

__All meats __Fibrous Meats __Can Only Tolerate Soft Solids

__Raw Vegetables __Fruits __ Cheese (melted or solid)

__Cooked Vegetables __Breads Other:

__Textures __Spicy

Reported Chewing Patterns

__Picky Eater __Noisy Eater __Audible Gulping __Chews with Lips Apart

__Messy __Gags Easily __Facial Discomfort __Coughs After Meals

__Relies on Drinks with Meals __Dental Factors Resulting in Adaptations

Other:

Somatosensory Systems Sensitivities

__Pain Sensitivities __Tags/Cloth Textures

__Temperatures __Sensitive to Touch

__Avoids Spicy Food __Enjoys Spicy Foods

__Proprioception Difficulties __Skin Neuralgia

__Motion Sickness

Other:

Pill Swallows

__Never Attempted

Large Pills __WNL* __w/Difficulty __Incapable

Small Pills __WNL* __w/Difficulty __Incapable

Comments:

Special Diet Considerations

__Gluten Free __Dairy Free __Egg __Red Dye __Paleo __Vegan __Nuts __Kosher

Other:

Habits

Digit Sucking	__Never	__Current	___Age Resolved	Comments:
Pacifier Usage	__Never	__Current	___Age Resolved	Comments:
Nail Biting	__Never	__Current	___Age Resolved	Comments:
Hair Twisting	__Never	__Current	___Age Resolved	Comments:
Trichotillomania	__Never	__Current	___Age Resolved	Comments:
Tongue Sucking	__Never	__Current	___Age Resolved	Comments:
Object Chewing	__Never	__Current	___Age Resolved	Comments:

Description:

Oral Family History

Tongue Tie	__No Known History	__Parents	__Sibling	__Relative
Lip Tie	__No Known History	__Parents	__Sibling	__Relative
Cleft Palate	__No Known History	__Parents	__Sibling	__Relative
Orthodontia	__No Known History	__Parents	__Sibling	__Relative

Other:

Person Completing this Form: _____
(please print)

Relationship to Patient: _____

Signed: _____ Date: _____