CHILD ASSESSMENT SHEET (PRE PROCEDURE)

Patient's Name _____Birthday _____Age____ Today's Date _____

Medical issues: _____ Medications taking: _____

Allergies: _____ Previous clip or release of tongue? _____(date)

1. Has your child experienced any of the following issues? Please check or elaborate as needed.

Speech

__ Frustration with communication
__ Difficult to understand by parents
__ Difficult to understand by outsiders
__ % Percent of time you understand your child
__ Difficulty speaking fast
__Difficulty getting words out (groping for words)
__ Trouble with sounds (which?)_____
__ Speech delay (when?)_____
__ Stuttering
__ Speech harder to understand in long sentences
__ Speech therapy (how long)_____
__ Mumbling or speaking softly
__"Baby Talk"

Feeding

__ Frustration when eating
__ Difficulty transitioning to solid foods
__ Slow eater (doesn't finish meals)
__ Small appetite / Trouble gaining weight
__ Grazes on food throughout the day
__ Packing food in cheeks like a chipmunk
__ Picky eater/ with textures (which?)_____
__ Choking or gagging on food
__ Spits out food
__Won't try new foods
__ Other:

Nursing or Bottle-Feeding Issues as a Baby

__ Painful nursing or shallow latch
__ Poor weight gain
__ Reflux or spitting up
__ Unable to hold pacifier
__ Milk dribbled out of mouth / messy eater
__ Poor Supply
__ Nipple shield required for nursing
__ Clicking or smacking noise when eating
__ Cried a lot / colic as baby
__ Other:

Sleep issues

__ Sleeps in strange positions
__ Sleeps restlessly (moves a lot)
__ Wakes easily or often
__ Wets the bed
__ Wakes up tired and not refreshed
__ Grinds teeth while sleeping
__ Sleeps with mouth open
__ Snores while sleeping (how often) _____
__ Gasps for air or stops breathing (sleep apnea)

Other related issues

__ Neck or shoulder pain or tension
__ TMJ Pain, clicking, or popping
__ Headaches or migraines
__ Strong gag reflex
__ Mouth open /mouth breathing during the day
__ Tonsils or adenoids removed previously
__ Ear tubes previously / lots of ear infections
__ Reflux (medicated or not)
__ Hyperactivity / Inattention
__ Constipation

Anything else we need to know:

Pediatrician _____Speech Therapist _____

Who referred you to us? _____Doctor's Signature _____