Parent Assessment Form

Please answer the questions below to the best of your knowledge. This questionnaire will provide a basis for my exam and allow me to focus on the specific symptoms your child displays.
A thorough exam of all your child's symtoms will be conducted on the day of the consultation.

1) _____ Has your child ever had a thumb or finger sucking habit?
2) _____ Has your child ever had allergies or food sensitivities?
3) _____ Do you notice that your child occasionally has his/her mouth open at rest?
4) _____ Has your child ever had troubles with speech, or been in a speech therapy program?
5) _____ Has anyone ever told you that your child may be tongue-tied?
6) _____ Did your child have any difficulties feeding as an infant?
7) _____ Has your child experienced any issues with digestion? (stomach aches, burping, gas, acid reflux, etc)
8) _____ Do you notice that your child has a hyper-active gag reflex?
9) _____ Does your child have difficulty swallowing pills?
10) _____ Does it seem like your child is a messier eater than other kids? (chews with mouth open, drinks and chews at same time, etc)
11) _____ Has your child experienced any breathing issues or difficulties? (chronic congestion, asthma, etc.)
12) _____ Has your child had their tonsils removed, or have you been told the tonsils are enlarged?
13) _____ Do you notice that your child tends to breathe through his/her mouth more often that their nose?

Generally, if any of these questions can be answered "yes" your child is likely to have some myofunctional concerns. If you can answer "yes" to multiple questions, myofunctional therapy will be recommended. Please fill out this form and email it back to me before your consultation.

Thank you very much for taking the time!