Orofacial Myology Case History

Name:_____ Date of Birth_____

Describe your concern:_____
Date of last dental exam: _____ Name of Dentist_____
Date of last orthodontic treatment: _____ Name of Orthodontist_____
Who referred you to Speech and Language Connections? _____

Dental / Medical Information:

1. Are you under the care of a physician? _____
   - If yes, what condition is being treated? _____
2. Have you been hospitalized over the last 5 years? _____
   - If yes, why?_____
3. Are you taking any drug, diet supplement or medication at this time?_____
   - If yes, please list name and dosage _____
4. Are you allergic to any medication, product (i.e. latex) or food? _____
   - If yes, which one? _____
5. Have you ever been treated or advised that you have any of the following?

Speech Disorder	Ulcers	Hepatitis
Heart Disorder	Diabetes	ADD/ADHD
Neurological Disorder	Cancer	Headaches
Pain in the jaw joint	Arthritis	Eating Disorder
Stroke	Fainting	Chronic Cough

6. Please briefly describe your orthodontic treatment? (i.e: palatal expansion followed by braces for X years, oral surgery, teeth extraction, etc) _____

_____

_____

_____

7. Have you had an orthodontic relapse? ☐ Yes ☐ No

8. Do you wear a retainer? ☐ Yes ☐ No

9. Do you suffer from allergies? ☐ Yes ☐ No
   If yes, to what? Medicine taken?_____

10. Have you had your tonsils / adenoids removed? ☐ Yes ☐ No
    Approximate year of surgery: _____
11. Do you suffer from any of the following?

Tooth ware	Gum Inflammation	Periodontal Disease
TMJ pain	Deviated Septum	Ear Infections

12. Do you breathe through your mouth, nose or both?_____

General Information

1. Have you ever had any injury involving your mouth, head, neck, or shoulder?_____
   If yes, please describe the injury and treatment: _____
2. Do you suffer from any disease or disorder affecting muscle strength or muscle movement (i.e. Cerebral Palsy, Bell's Palsy)?_____
   If yes, please describe the disease or disorder: _____
3. Do you play a musical instrument?_____
   If yes, which one? Number of hours of practice a day?_____
4. Do you play any sport? _____
   If yes, which one? Number of hours of practice a day?_____
5. Do you grind you teeth?_____
6. Do you sleep on your right or left side / back / stomach? _____
   Do you snore? If so, is the snoring loud?_____
   Do you snore frequently or occasionally?_____
7. Do you suffer from sleep apnea?_____
   If yes, do you use a C-PAP machine? _____
8. Do you have any of the following habit?

Chewing on a pen	Sucking your tongue	
Nail biting	Biting your lip	Chewing inside of your cheeks
Chewing on hair	Thumb or finger sucking	Resting your face in your hand
Smacking your lips	Licking your lips	

9. Do you have any loose tooth, or noticed a change in a tooth?_____
10. How often do you brush your teeth?_____
11. Do you frequently get cold sores, blisters, or any other oral lesions?_____
12. Do you have tired jaw, especially in the morning?_____
13. Have you noticed any change in your teeth or change in your bite?_____
14. Do you mouth breathe when you are asleep?_____
15. Do you mouth breathe during the day?_____
16. Do you hear any click, pops or grating sounds in your jaw joints?_____
17. Has your jaw ever locked opened or closed?_____
18. Have you ever had jaw surgery?_____
19. What are your goals for orofacial myofunctional treatment?_____

_____

_____

_____

Client/Parent's Signature: _____

Date: _____