

## 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 currently taking any drugs, diet supplements or medication? \_\_\_\_\_

- If yes, please list names 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, tooth 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 wear	Gum Inflammation	Periodontal Disease
TMJ pain	Deviated Septum	Ear Infections

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

## General Information

13. Have you ever had any injury involving your mouth, head, neck, or shoulder? \_\_\_\_\_  
If yes, please describe the injury and treatment: \_\_\_\_\_
14. 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: \_\_\_\_\_
15. Do you play a musical instrument? \_\_\_\_\_  
If yes, which one? Number of hours of practice a day? \_\_\_\_\_
16. Do you play any sport? \_\_\_\_\_  
If yes, which one? Number of hours of practice a day? \_\_\_\_\_
17. Do you grind your teeth? \_\_\_\_\_
18. 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? \_\_\_\_\_
19. Do you suffer from sleep apnea? \_\_\_\_\_  
If yes, do you use a C-PAP machine? \_\_\_\_\_
20. Do you have any of the following habits?  
 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
21. Do you have any loose teeth, or noticed a change in a tooth? \_\_\_\_\_
22. How often do you brush your teeth? \_\_\_\_\_
- 23.. Do you frequently get cold sores, blisters, or any other oral lesions? \_\_\_\_\_
24. Do you have tired jaw, especially in the morning? \_\_\_\_\_
25. Have you noticed any change in your teeth or change in your bite? \_\_\_\_\_
26. Do you mouth breathe when you are asleep? \_\_\_\_\_
27. Do you mouth breathe during the day? \_\_\_\_\_
28. Do you hear any click, pops or grating sounds in your jaw joints? \_\_\_\_\_
29. Has your jaw ever locked opened or closed? \_\_\_\_\_
30. Have you ever had jaw surgery? \_\_\_\_\_
31. What are your goals for orofacial myofunctional treatment? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Client/Parent's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_