AIRWAY FOUNDATIONS
AT HYLAND DENTAL

Myofunctional Therapy Assessment Form

Patient Name: _____ Date: _____

Responsible Party: _____

(name) (relationship)

Please answer the questions below to the best of your knowledge. This form will provide a basis for our exam and allow us to focus on the specific symptoms your child displays. A thorough exam of all symptoms will be conducted on the day of the consultation.

1. Yes/No Has your child ever had a thumb, finger, or foreign object (pen, nail, hair, etc.) sucking habit? If yes, what? _____
2. Yes/No Has your child ever had allergies or food sensitivities? If yes, what? _____
4. Yes/No Has your child ever had troubles with speech or been in a speech therapy program?
5. Yes/No Has anyone ever told you that your child may be tongue-tied?
6. Yes/No Did your child have any difficulties feeding as an infant?
7. Yes/No Has your child experienced any issues with digestion (stomach aches, burping, gas, acid reflux, etc.)?
8. Yes/No Do you notice that your child has a hyper-active gag reflex?
9. Yes/No Does your child have difficulty swallowing pills?
10. Yes/No Does it seem like your child is a messier eater than other kids (chews with mouth open, drinks and chews at the same time, etc.)?
11. Yes/No Has your child experienced any breathing issues or difficulties (chronic congestion, asthma, etc.)?
12. Yes/No Has your child had their tonsils removed or have you been told the tonsils are enlarged?
13. Yes/No Do you notice that your child tends to breathe through his/her mouth more often than 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.
Thank you very much for taking the time to complete this assessment.

Additional Notes:

Check all that apply for the patient being evaluated

O ADHD
O Anxiety/Depression
O Autism
O Bad breath
O Blocked/runny nose
O Bruxism (teeth grinding/clenching)
O Cerebral Palsy
O Dark circles under eyes
O Difficulty concentrating
O Difficulty getting to sleep
O Difficulty staying asleep?
O Drool while sleeping
O Dry mouth
O Exhausted on walking
O Fatigue
O Fidgety
O Gingivitis
O Insomnia
O Irritable
O Lack of stamina
O Many cavities
O Mouth breathing during sleep
O Nightmares
O Noisy breathing during sleep
O Physical Exhaustion
O Snoring
O Sleep Apnea
O Sleep lightly/easily roused
O Sleep walk/talk
O Sleep with body in odd positions
O Sleep with head extended back
O Sweating
O Throat clearing
O TMJ Disorder
O Toss & turn while asleep
O Upper chest breathing
O Wake up with a gasp/startle
O Wet the bed
O Wake up in the night and trouble falling back asleep
O Wake up groggy/moody
O Wake up in a tangle of bedding/wrong side of the bed
O Wake up with a gasp/startle
O Wake up with a headache
O Wet the bed
O Prior tongue tie release
O Prior orthodontics
O Prior jaw or maxillofacial surgery
O Prior myofunctional therapy
O Prior breathing therapy

Average Hours of Sleep _____

Infant History:

O Breastfed _____months

O Bottlefed _____ months

O Pacifier until age _____

Headache History:

Location _____

Frequency _____

Pain _____

(mild, moderate, severe)

I have truthfully answered all of the above questions and agree to inform Hyland Dental of any changes in medical history. In addition, I certify that I have custody and do authorize informed consent for Hyland Dental to perform a completed medical, dental, and/or myofunctional evaluation of the patient.

Responsible Party Signature _____ Date _____