



Sensory Solutions, LLC

Physical, Speech, Occupational, and Nutritional Health for Children

Patient History-Tongue/Lip/Cheek Ties:

***Please fill out the questionnaire as accurately and completely as possible.**

Patient's Name: _____ Birth Date: _____

Person Completing this Form and Relationship: _____

Referred By: _____

Diagnosis(es) (i.e., Tongue tie, sleep apnea, ADHD, etc.): _____

Parent/Guardian Name: _____

Relationship to patient: Biological Foster Adoptive Other: _____

Address: _____

Parent/Guardian Name: _____

Relationship to patient: Biological Foster Adoptive Other: _____

Address: _____

Marital Status (Please check one): Married Separated Divorced Widowed
 Single Domestic Partnership

Emergency Contact information:

Name: _____ Relationship: _____

Phone Number: _____

Primary Care Physician: _____

MEDICAL HISTORY:

Pregnancy: Full Term Premature

Length of Pregnancy _____ weeks/months (please circle one)

Problems encountered during pregnancy (i.e., illness, injuries, bleeding, fainting spells, anemia, etc.): _____



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Delivery Type: Vaginal C-section

Complications following birth: _____

Birth Weight: lbs. oz.

Were there any feeding difficulties at birth: Yes No

If yes, please specify: _____

Was the patient breast or bottle fed and for how long: _____

List illnesses/diseases/injuries/operations/ear infections/diagnoses the patient has experienced/received:

1) _____ Age: _____

2) _____ Age: _____

3) _____ Age: _____

4) _____ Age: _____

5) _____ Age: _____

History of acid reflux: Yes No

Allergies:

None

Seasonal

Food

Other

Please list all allergies: _____

Is the patient currently taking any medications/vitamins/supplements: Yes No

If yes, type(s): _____



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Date of last hearing evaluation: _____ Results: _____

Location hearing evaluation was performed: _____

Date of last vision evaluation: _____ Results: _____

Location vision evaluation was performed: _____

DEVELOPMENTAL HISTORY:

In terms of developmental milestones (crawling, walking, talking, etc.), did the patient:

Meet all milestones age-appropriately

Meet all milestones early

Meet all milestones late

Other: _____

CURRENT RESPONSE DURING FEEDING:

Behavior	Always/Often/ Sometimes/Never	Additional Comments
Acid Reflux		
Choking		
Coughing		
Difficulty Chewing		
Drooling		
Eating Too Fast		
Eating Too Slow		
Fails To Chew Food		
Gagging		
Hiccapping		
Holding Food in Mouth		
Nasal Regurgitation		
Pockets Food		
Poor Intake		
Spillage of Food/Liquid		
Spits Out Food		
Stuffs Mouth		
Vomiting		

SYMPTOMS (CHECK ALL THAT APPLY):

Frequent Headaches/Migraines



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- TMJD (Temporomandibular Joint Disorder)
- Jaw Clicking/Popping
- Teeth Grinding
- Tightness in Neck and/or Shoulders
- Articulation/Speech Sound Production Difficulties
- Sleep Apnea: Suspected Diagnosed If Diagnosed, When: _____
- Mouth Breathing
- Tongue Thrust
- Narrow Palate
- Inability to Clear Food from Teeth with Tongue
- Forward Head Posture
- Poor Overall Posture
- Acid Reflux or History of
- Congestion When Falling Asleep/Waking
- Occasional Bed Wetting
- Difficulty Falling Asleep or Staying Asleep
- Selective/Picky Eater
- Bad Breath
- Frequent Cavities
- Pain or Difficulty when Kissing
- Frequent Choking on Foods/Liquids
- Thumb/Finger Sucking (or history of)
- Nail Biting
- Snoring
- Other (please specify): _____

HISTORY OF:

- Braces When and how many times: _____
- Invisalign When: _____
- Palate Expander When: _____
- Spacers When: _____
- Sleep Study When: _____

Person completing this form: _____

Date: _____