INTAKEQ4U - INTAKE FORM

Welcome! Thank you for choosing our office. We strive to provide you with the most quality care possible. If you have any questions, or if we can help you in any way, please feel free to ask

1. Please enter your information.

Full Name

Preferred Name/Nickname:

If Child, Parent/Guardian Name:

Birthdate:

Gender:
○ Female ○ Male

Preferred Pronouns:

Age:

Social Security Number:

Home Address:

Apt./Unit #:

City:

State:

Zip Code:

Mobile Phone:

Home Phone:

Email:

If Child, Parent/Guardian's Email:

Preferred Contact Method:
☐ Mobile Phone ☐ Home Phone ☐ Work Phone
☐ Email

2. How did you hear about our practice?

Referral source:

Reason for visit:

Goals for treatment:

3. In case of an emergency:

Primary care physician:

Phone number:

Emergency name contact:

Phone number:

Myofunctional & Medical History Form

4. Have you ever had any major operations, to include frenectomy (tongue or lip tie release),

tonsillectomy, adenectomy, myringotomy (ear tubes), and/or periodontal or oral surgery, facelift, etc. Please include the year.

- ○ Yes
- ○ No

5. If yes, please provide details:

_____

_____

_____

_____

6. Have you ever had any cosmetic injectables or Botox/Dysport injections for any reason?

- ○ Yes
- ○ No

Describe type of injectable and last date of service.

_____

7. If yes, please provide details.

_____

_____

_____

_____

8. Are you currently taking any medications, drugs, and/or nutritional supplements?

- ○ Yes
- ○ No

9. If yes, please list:

_____

_____

_____

_____

10. Are you allergic to (or have a history of allergic reactions) to include any medications, anesthetics, foods, drugs, latex, adhesive/medical tape, or nitrile.

- ○ Yes
- ○ No

11. If yes, please list:

_____

_____

_____

_____

12. Have you ever seen an allergist and/or had allergy testing?

☐ Yes ☐ No

13. Do you have any food allergies, intolerances, or other eating restrictions (vegetarian, vegan, gluten-free, etc.)?

- ○ Yes
- ○ No

14. If yes, please list:

_____

_____

_____

_____

15. Do you have a history of vaping, smoking, or the use of smokeless tobacco?

- ○ Yes
- ○ No

16. Do you drink alcohol?

- ○ Yes
- ○ No

17. If yes, how much & how often?

_____

18. Do you have a tendency towards colds, strep throat, sore throats, ear infections, and/or headaches?

- ○ Yes
- ○ No

19. If yes, please explain:

_____

_____

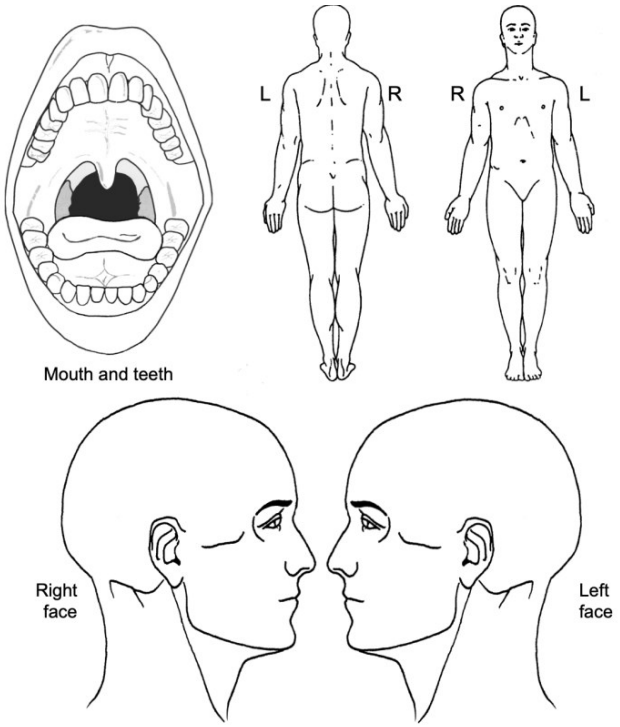
_____

_____

20. Do you experience any popping, clicking, locking, fatigue, limited opening, or other jaw issues?

- ○ Yes, with pain
- ○ Yes, without pain
- ○ No

21. Indicate the location of ALL of your different pains by shading in the area, using the diagrams that are most relevant. If there is an exact spot where the pain is located, indicate with a solid dot (•). If your pain moves from one location to another, use arrows to show the path.



22. Do you ever clench or grind your teeth?

- ○ Yes
- ○ No

23. Please elaborate.

_____

_____

_____

_____

24. Have you ever been treated for a TMJ problem (TMD or TMJD)?

- ○ Yes
- ○ No

25. If yes, please explain:

_____

_____

_____

_____

26. Do you experience headaches and/or ringing in the ears?

- ○ Yes
- ○ No

27. If yes, please explain:

28. Have you had a history of car accidents and/or other trauma to the head/neck?

- Yes
- No

29. If yes, please explain:

30. Do you experience acid reflux or heartburn?

- Yes
- No

31. Do you often breathe through your mouth at night or during the day?

- Yes
- No

32. If yes, please explain:

33. Do you ever feel like you have difficulty breathing through your nose?

- Yes
- No

34. If yes, please explain:

35. Do you snore, breathe heavily, or stop breathing when you sleep?

- Yes
- No

36. If yes, please explain:

37. How do you normally sleep at night? (Back, side, stomach or a combination? Do you normally sleep with your hands on your face or underneath your pillow?)

38. Is your pillow ever wet when you wake up?

- Yes
- No

39. Do you ever wet the bed?

- Yes
- No

40. Do you use allergy covers on your bed and pillows? And do you change your sheets frequently?

41. Does a pet also sleep in your bed?

42. Have you ever done a sleep study or been screened for a sleep disorder?

- Yes
- No

If so, when was your last sleep study? Was it done home or in a sleep lab? What were the results?

43. If yes, please explain:

44. Do you feel well-rested when you wake?

- ○ Yes
- ○ No

45. Have you ever had speech therapy?

- ○ Yes
- ○ No

46. If yes, please explain (which letters or sounds and date ranges):

_____

_____

_____

_____

47. Any history of feeding, physical, or occupational therapy?

- ○ Yes
- ○ No

48. If yes, please explain.

_____

_____

_____

_____

49. Have you ever had orthodontic treatment?

- ○ Yes
- ○ No

50. If yes, please explain:

_____

_____

_____

_____

51. Have you ever worn an expander, head gear, habit appliances (including tongue rake or thumb crib), or other fixed or removable orthodontic appliances?

- ○ Yes
- ○ No

52. If yes, please explain:

_____

_____

_____

53. Have you ever had teeth removed for braces?

- Yes
- No

54. If yes, please explain:

55. Do you wear dentures, retainers, a night guard, or other removable dental appliances? Or do you have permanent retainers or other appliances bonded to your teeth?

- Yes
- No

56. If yes, please explain:

57. Please describe birth history (Prematurity? A long or difficult birth? Any complications?)

58. Were you breast or bottle fed and for how long? Did you have any difficulty latching or any other issues?

59. Describe transition from formula and/or breast milk to food (When was baby food used, and for how long?)

60. Were there ever any concerns about growth and/or meeting developmental milestones growing up?

- ○ Yes
- ○ No

61. Do you play an instrument or sing?

- ○ Yes
- ○ No

62. What instrument? Or are you a vocalist?

_____

63. Do you often have cracked, chapped lips?

- ○ Yes
- ○ No

64. Do you experience bad breath frequently?

- ○ Yes
- ○ No

65. If so, please elaborate. Are they ongoing? When did they stop?

_____

_____

_____

_____

66. List any triggers for the habit(s), if applicable:

- ☐ Pillow
- ☐ Stuffed animals
- ☐ Blanket
- ☐ Hair
- ☐ Boredom
- ☐ Fatigue
- ☐ Fear
- ☐ Punishment
- ☐ Anxiety
- ☐ Car Rides
- ☐ Playing
- ☐ TV
- ☐ Homework
- ☐ Other

If other, please specify:

_____

67. Have you ever been diagnosed and/or treated for the following?

- ☐ Frequent headaches
- ☐ Tinnitus
- ☐ ADD/ADHD
- ☐ Herpes, cold sores, or fever blisters
- ☐ Bell's palsy
- ☐ Cerebral palsy
- ☐ Down syndrome
- ☐ Mitral valve prolapse
- ☐ Shortness of breath
- ☐ Other congenital heart disease
- ☐ High or low blood pressure
- ☐ Hay fever
- ☐ Cancer
- ☐ Hepatitis
- ☐ AIDS or HIV positive
- ☐ Blood or bleeding disorders
- ☐ Blood transfusions
- ☐ Anemia

- ☐ Stroke
- ☐ Torticollis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Rapid weight loss or gain
- ☐ Sinus problems
- ☐ Gum surgery
- ☐ Burning mouth syndrome
- ☐ Artificial joints
- ☐ Psychologic care
- ☐ Drug Dependency
- ☐ Arthritis
- ☐ Visual or hearing impairment
- ☐ Neck & shoulder pain
- ☐ Bite treatment (other than braces)
- ☐ Tourette's syndrome
- ☐ Alzheimer's disease
- ☐ Kidney or liver disease
- ☐ Osteoporosis
- ☐ Pain in multiple joints
- ☐ Tick bite
- ☐ Dental implants
- ☐ Genetic disorders
- ☐ Other

Other illnesses not checked above:

_____

68. Please list the medications you are currently taking.

_____

_____

_____

_____

69. If more than one person is attending this appointment, please indicate if you would prefer to speak privately with your myofunctional therapist about a medical issue.

- ○ Yes
- ○ No
- ○ Not Applicable

I understand that the above information is necessary to provide me with myofunctional therapy in a safe and efficient manner. I have answered all questions to the best of my knowledge. I understand that I will need to notify my orofacial myofunctional therapist when there are any changes to my health, including medications, allergies, medical problems, and surgeries.

Patient or Parent/Guardian

_____ _____

Signature Date

Home Observation Sheet

70. Position of lips during the day:

- ☐ Open slightly
- ☐ Closed
- ☐ Lips closed but jaw position low
- ☐ Lips closed but strong contraction of the chin and lip muscles
- ☐ Teeth positioned over lower lip
- ☐ Other

If other, please specify:

_____

71. What percentage of the time?

_____

72. Position of the tongue during the day:

- ☐ Protruding between both teeth and lips
- ☐ Protruding slightly between the teeth
- ☐ Low positioned pressing against the lower teeth
- ☐ Unobservable, lips closed
- ☐ Other

If other, please specify:

_____

73. What percentage of the time?

_____

74. Chewing and drinking patterns:

- ☐ Chewing with lips open
- ☐ Chewing with excessive lip and chin movements
- ☐ Chewing with lips closed
- ☐ Chewing with lips closed, but excessive lip and chin movement
- ☐ Alternating chewing sides
- ☐ Favors one side during chewing
- ☐ Noisy chewing, smacking, etc
- ☐ Forward thrusting of the tongue during swallowing
- ☐ Reaching out of tongue to meet the glass
- ☐ Touching of teeth to utensil, cup, glass
- ☐ Reaching of tongue toward fork, spoon, cup
- ☐ Excessive crumbs around mouth or left on table
- ☐ Frequent lip licking
- ☐ Large bites
- ☐ Fast chewing and/or gulping
- ☐ Slow eating
- ☐ Washing down foods with water
- ☐ Other

If other, please specify:

_____

75. What percentage of the time?

_____

76. Position of the tongue, lips, and teeth during sleep:

- ☐ Lips slightly apart
- ☐ Lips apart, tongue showing
- ☐ Mouth breathing
- ☐ Lips closed
- ☐ Other

If other, please specify:

_____

77. What percentage of the time?

_____

78. Do you have a history of any of the following oral habits?

Oral Habit	Current Habit	Former Habit
Thumb (or other finger) sucking		
Tongue sucking		
Pacifier use		
Nail biting		
Object biting or chewing		
Holding things between the teeth (for example, bobby pins or nails)		
Other habits or tics		

79. How often do you do each of the following activities, based on the last month. If the frequency of the activity varies, choose the higher option.

Oral Behaviors	<1 Night/Month	1-3 Nights/Month	4-7 Nights/Week	None	Previous History
Clench or grind teeth when asleep, based on any information you may have					
Sleep in a position that puts pressure on the jaw (for example, on stomach, on side					
Grind teeth together during waking hours					
Clench teeth together during waking hours					
Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth)					
Hold, tighten, or tense muscles without clenching or bringing teeth together					
Hold or jut jaw forward or to the side					
Press tongue forcibly against teeth					
Place tongue between teeth					

Bite, chew, or play with your tongue, cheeks, or lips					
Hold jaw in a rigid or tense position, such as to brace or protect the jaw					
Hold between the teeth or bite objects such as hair , pipe, pencil, pens, fingers, fingernails, etc					
Use chewing gum					
Play muscle instrument that involves the use of mouth or jaw (for example: woodwind, brass, string instruments)					
Lean with your hand on the jaw, such as cupping or resting the chin on the hand					
Chew food on one side only					
Eating between meals (that is, food that requires chewing)					
Sustained talking (for example: teaching, sales, customer service)					
Singing					
Yawning					
Hold the telephone between your head and shoulders					

Bears Sleep Screening Algorithm

(For Children under Age 18)

80.

	Toddler/Preschool (2-5 years)	School-aged (6-12 years)	Adolescent (13-18 years)
1. Bedtime problems	Does your child have any problems going to bed? Falling asleep?	Does your child have any problems at bedtime? (P) Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C)
2. Excessive daytime sleepiness	Does your child seem overtired or sleepy a lot during the day? Does she still take naps?	Does your child have difficulty waking in the morning, seem sleepy during the day or take haps? (P) Do you feel tired a lot? (C)	Do you feel sleep a lot during the day? In school? While driving? (C)
3. Awakenings during the night	Does your child wake up a lot at night?	Does your child seem to wake up a lot at night? Any sleepwalking or nightmares? (P) Do you wake up a lot at night? Have trouble getting back to sleep? (C)	Do you wake up a lot at night? Have trouble getting back to sleep? (C)
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? What are they?	What time does your child go to bed and get up on school days? Weekends? Do you think he/she is getting enough sleep? (P)	What time do you usually go to bed on school nights? Weekends? How much sleep do you usually get? (C)
5. Snoring	Does your child snore a lot or have difficulty breathing at night?	Does your child have loud or nightly snoring or any breathing difficulties at night? (P)	Does your teenager snore loudly or nightly? (P)

(P) Parent-directed question (C) Child-directed question

Source: “A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems” by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins

Epworth Sleepiness Scale Screening Questionnaire

(For Adults Aged 18 and Older)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

81. Chance of Dozing (On a 0-3 Scale)

	0	1	2	3
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
n a car, while stopped for a few minutes in the traffic	0	1	2	3

82. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

83. Please upload images of your medical insurance card.

84. This questionnaire: © 2022. Pittsburgh Orofacial Myofunctional Therapy, LLC. All Rights Reserved.