Welcome Wellness
Myofunctional Intake Form

Please download, complete, save, and email form to smile@welcomewellness.ca

Dental Information
If applicable

Dentist's Name, Address, and Phone Number

Orthodontist's Name, Address, and Phone Number

Who would you like a report sent to?

☐ Dentist ☐ Orthodontist ☐ Both ☐ None ☐ N/A

Educational Information
If applicable

School Child Attends:

Grade:

Special Education Services Received:

Ex. speech, OT, PT, resource room, other

Extra Curricular Acitivites:

Do you/they play a musical instrument?

☐ Yes ☐ No

If so, what instrument?

If so, how many days per week?

If so, how many hours per day?

Employment
If applicable

Occupation:

Are you required to sit for extended periods of time?

☐ Yes ☐ No

Does your employment require travel?

☐ Yes ☐ No

Birth History
To be completed by all patients as thoroughly as possible

Gestation age in weeks:

Birth weight:

Type of birth:

☐ Caesarian ☐ Vaginal

Duration of labor:

Describe any birthing complications:

Describe any breathing difficulties:

Was the baby discharged with mom:

☐ Yes ☐ No

If no, please describe:

Feeding History
To be completed by all patients as thoroughly as possible

Breast Fed?

☐ Yes ☐ No ☐ N/A

Duration of breast feeding:

Was nursing painful for the mother?

☐ Yes ☐ No

Was the mother's milk supply poor?

☐ Yes ☐ No

Describe any complications (for the mother or baby) during breast feeding:

Bottle Fed?

☐ Yes ☐ No ☐ N/A

Duration of breast feeding:

Describe any complications (for the mother or baby) during bottle feeding:

Were clicking or smacking noises heard while nursing or bottle feeding?

☐ Yes ☐ No

Did milk dribble out of the mouth when bottle or breast feeding?

☐ Yes ☐ No

Did the baby have difficulty transitioning from breast/or bottle to purees??

☐ Yes ☐ No

If yes, please describe:

Was there a history of spitting up or reflux after eating?

☐ Yes ☐ No

If yes, please describe:

Was choking or gagging ever observed while eating?

☐ Yes ☐ No

Does/did the patient spit out food?

☐ Yes ☐ No

Is/was the patient a picky eater?

☐ ☐

What foods does the patient prefer to eat?

What foods does the patient avoid?

Does/did the patient show frustration when eating?

☐ Yes ☐ No

How does the patient chew and swallow food?

☐ Slowly ☐ Just right ☐ Does not chew food thoroughly

Is the patient's bite size:

☐ Too small ☐ Just right ☐ Too large

Does the patient chew with an open mouth?

☐ Yes ☐ No

Is the patient a noisy eater?

☐ Yes ☐ No

Does the patient have difficulties swallowing liquids?

☐ Yes ☐ No

Does the patient have difficulties swallowing purees?

☐ Yes ☐ No

Does the patient have difficulties swallowing solids?

☐ Yes ☐ No

If yes, please describe:

List any dietary restrictions:

Sucking Habits
To be completed by all patients as thoroughly as possible

Do you suck your thumb?

☐ Yes ☐ No

Which thumb do you suck?

☐ Left ☐ Right ☐ Both ☐ N/A

Do you suck your finger(s)?

☐ Yes ☐ No

Which finger(s) do you suck?

☐ Left ☐ Right ☐ Both ☐ N/A
☐ Pinky ☐ Ring ☐ Middle ☐ Index

When do you suck your thumb(s)/finger(s)??

☐ Day ☐ Night ☐ School ☐ N/A
☐ Work ☐ Anxious ☐ Tired ☐ Worried
☐ Bored ☐ In the car ☐ Watching TV ☐ Other

Did you ever suck your thumb or finger?

☐ Yes ☐ No

If yes, at what age did you stop?

Did you ever suck a pacifier?

☐ Yes ☐ No

If yes, at what age did you stop?

Have you ever tried to stop your sucking habit?

☐ Yes ☐ No

What strategies did you try?

Would you like to eliminate your sucking habit?

☐ Yes ☐ No ☐ N/A

Developmental Milestones
To be completed for children 0-18 years of age. Please include the age the patient did the following:

Rolled over:

Sat unsupported:

Crawled:

Stood next to things:

Stood alone:

Walked along furniture:

Walked:

Used a utensil:

Self fed:

Drank from a cup:

Dressed self:

Spoke single words:

Spoke in sentences:

Medical History
Please complete with as much detail as possible

Recurrent illness?

☐ Yes ☐ No

Explain:

Hospitalization or surgeries?

☐ Yes ☐ No

Explain:

How many hours/week do you exercise?

How many meals do you eat in a day?

Acid reflux/GERD?

☐ Yes ☐ No

Is the patient vaccinated?

☐ Yes ☐ No

Were there ever any adverse reactions to vaccinations?

☐ ☐ ☐

Explain reaction:

Has the patient been diagnosed with a neurological impairment or syndrome?

☐ Yes ☐ No

If yes, explain:

Has the patient been diagnosed with a syndrome?

☐ Yes ☐ No

If yes, explain:

Has the patient had their vision evaluated?

☐ Yes ☐ No ☐ WNL ☐ Needs glasses ☐ Wears glasses or contacts

Head
To be completed by all patients

Headaches

☐ Mild ☐ Moderate ☐ Severe ☐ Past ☐ N/A

Head Injury

☐ Mild ☐ Moderate ☐ Severe ☐ Past ☐ N/A

Migraine headaches

☐ Mild ☐ Moderate ☐ Severe ☐ Past ☐ N/A

Jaw/TMJ problems

☐ Mild ☐ Moderate ☐ Severe ☐ Past ☐ N/A

Ears/Nose/Throat
To be completed by all patients

Last hearing evaluation?

Impaired hearing

- [ ] Yes
- [ ] No
- [ ] Unilateral hearing loss (left)
- [ ] Unilateral hearing loss (right)
- [ ] Bilateral hearing loss
- [ ] Conductive hearing loss
- [ ] Sensorineural hearing loss

Tinnitus (ringing)

- [ ] Yes
- [ ] No
- [ ] Past

Earache/Ear infections

- [ ] Yes
- [ ] No
- [ ] Past

PE Tubes

- [ ] Yes
- [ ] No
- [ ] Past

Dizziness

- [ ] Yes
- [ ] No
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Past

Vertigo

- [ ] Yes
- [ ] No
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Past

Has the patient been seen by an ENT doctor?

- [ ] Yes
- [ ] No

If yes, explain: (date and outcome)

Post nasal drip

- [ ] Yes
- [ ] No
- [ ] Past

Congestion

- [ ] Yes
- [ ] No
- [ ] Past

Frequent colds

☐ Yes ☐ No ☐ Past

Nasal polyps

☐ Yes ☐ No ☐ Past

Adenoids

☐ N/A ☐ WNL ☐ Enlarged ☐ Adenoidectomy

If yes, explain: (date, doctor who performed the surgery and outcome)

Sore throat/tonsillitis/strep throat

☐ Yes ☐ No ☐ Past ☐ Tonsillectomy

If yes, explain: (date, doctor who performed the surgery and outcome)

Problems with taste

☐ Yes ☐ No ☐ Past

Hoarseness

☐ Yes ☐ No ☐ Past

Dental/Mouth
To be completed by all patients

Cavities

☐ Yes ☐ No

Gum disease (periodontitis)

☐ Yes ☐ No

Teeth crowding

☐ Yes ☐ No ☐ Past

Narrow palate

☐ Yes ☐ No ☐ Past

Palatal expander

☐ Yes ☐ No ☐ Past

If yes or past, who prescribed it and when was it removed?

Braces

☐ Yes ☐ No ☐ Past

If yes or past, who prescribed them, how long have you had them, or when were they removed?

Mouth sores

☐ Yes ☐ No ☐ Past

Has the patient ever been told a frenectomy (tongue-tie release) was needed?

☐ Yes ☐ No ☐ Past

Has the patient ever had a frenectomy?

☐ Yes ☐ No ☐ Past

If yes, when was it performed and by who?

Jaw/TMJ problem

☐ Yes ☐ No ☐ Past

Does the patient wear an appliance?

☐ Yes ☐ No ☐ Past

If yes or past, what type of appliance and what is the purpose of the appliance?

Teeth extractions

☐ Yes ☐ No

If yes, how many teeth have been extracted and why?

Strong gag reflex

☐ Yes ☐ No

Gastrointestinal
To be completed by all patients

Heartburn

☐ Yes ☐ No ☐ Past

Trouble swallowing

☐ Yes ☐ No ☐ Past

Constipation

☐ Yes ☐ No ☐ Past

Belching/Flatulence

☐ Yes ☐ No

Tube feed

☐ Yes ☐ No ☐ Past

If yes or past, please explain type of feeding and why?

Indigestion

☐ Yes ☐ No ☐ Past

Vomiting

☐ Yes ☐ No ☐ Past

Bloating

☐ Yes ☐ No ☐ Past

Respiratory/Disordered Breathing
To be completed by all patients

Asthma

☐ ☐ ☐

Bronchitis

☐ Yes ☐ No ☐ Past

Difficulty breathing

☐ Yes ☐ No ☐ Past

Shortness of breath

☐ Yes ☐ No ☐ Past

Pneumonia

☐ Yes ☐ No ☐ Past

Heavy breathing during the day

☐ Yes ☐ No ☐ Past

Heavy breathing while sleeping

☐ Yes ☐ No ☐ Past

Snoring

☐ Yes ☐ No ☐ Past

Sleep apnea

☐ Yes ☐ No ☐ Mild ☐ Moderate
☐ Severe ☐ CPAP ☐ Sleep appliance

If yes, please list the date of diagnosis and name of the doctor

Restless while sleeping

☐ Yes ☐ No ☐ Past

Stops breathing while sleeping

☐ Yes ☐ No ☐ Past

Bed wetting

☐ Yes ☐ No ☐ Past

Difficult to wake up

☐ Yes ☐ No ☐ Past

Wakes up feeling unrefreshed

☐ Yes ☐ No ☐ Past

Wakes with headaches

☐ Yes ☐ No ☐ Past

Daytime sleepiness

☐ Yes ☐ No ☐ Past

Nightmares/screams in sleep

☐ Yes ☐ No ☐ Past

Grinds teeth while sleeping

☐ Yes ☐ No ☐ Past

Difficulty focusing during the day

☐ Yes ☐ No ☐ Past

Behaviour concerns

☐ Yes ☐ No ☐ Past

Abnormal sleep patterns

☐ Yes ☐ No ☐ Past

Sleep with mouth open

☐ Yes ☐ No

Drools while sleeping

☐ Yes ☐ No

Allergic/Environmental Exposures/Immunologic
To be completed by all patients

Food allergies or sensitivities

☐ Yes ☐ No ☐ Past

If yes or past, list allergies

Smoke exposure

☐ Yes ☐ No

Mold exposure

☐ Yes ☐ No

Pet in the home

☐ Yes ☐ No

Environmental allergies

☐ Yes ☐ No ☐ Past

If yes or past, list allergies

Speech/Language
To be completed by all patients birth to 18

Frustrated with communication

☐ Yes ☐ No ☐ N/A

Difficult to understand by in house family members

☐ Yes ☐ No ☐ N/A

Difficult to understand by outsiders (e.g. grandparents, aunts, uncles, teachers)

☐ Yes ☐ No ☐ N/A

Stutters on word, phrases or sentences

☐ Yes ☐ No ☐ N/A

Difficulty expressing needs, wants, or thoughts

☐ Yes ☐ No ☐ N/A

Explain how needs and wants are met (e.g. pointing, signing, screaming)

Difficulty following directions

☐ Yes ☐ No ☐ N/A

Difficulty using age appropriate vocabulary

☐ Yes ☐ No ☐ N/A

Difficulty answering questions

☐ Yes ☐ No ☐ N/A

Difficulty asking questions

☐ Yes ☐ No ☐ N/A

Difficulty using correct grammar

☐ Yes ☐ No ☐ N/A

Difficulty speaking sounds correctly

☐ Yes ☐ No ☐ N/A

Difficulty playing with other children

☐ Yes ☐ No ☐ N/A

Difficulty interacting with others

☐ Yes ☐ No ☐ N/A

Difficulty initiating conversation

☐ Yes ☐ No ☐ N/A

Difficulty transitioning between activities

☐ Yes ☐ No ☐ Sometimes ☐ N/A

Explain if yes or sometimes

Difficulty following routines

☐ Yes ☐ No ☐ N/A

Difficulty coping with changes in routine

☐ Yes ☐ No ☐ N/A

Explain your concerns for the patient's speech and language skills

Therapies
To be completed by all patients

Speech therapy

☐ Yes ☐ No ☐ Past

If yes or past, list place and length of service

Physical therapy

☐ Yes ☐ No ☐ Past

If yes or past, list place and length of service

Vision therapy

☐ Yes ☐ No ☐ Past

If yes or past, list place and length of service

Counseling

☐ Yes ☐ No ☐ Past

List any other therapies not listed above (state place and length of service)