ADULT ASSESSMENT

Name _____Date of Birth _____ Age_____ Today's Date _____

Medical issues: _____ Medications taking: _____

Allergies: _____ Previous clip or release of tongue? _____(date)

1. Have you experienced any of the following issues? Please check or elaborate as needed.

Speech Issues
___ Others have a hard time understanding speech
___ Embarrassed with communication
___ Shy in social situations
___ Difficulty speaking fast
___ Difficulty getting certain words out
___ Trouble with sounds (which?)_____
___ Speech delay (when?)_ _____
___ Stuttering
___ Jaw gets tired when talking or reading aloud
___ Speech harder to understand in long sentences
___ Speech therapy (how long) _____
___ Mumbling or speaking softly
___ Difficulty singing

Feeding Issues
___ Breastfed or ___ Bottle-fed as a baby
___ Fussy, colicky, or "difficult" as a baby
___ Frustrated when eating currently
___ Slow eater (last one to finish a meal)
___ Small appetite
___ Graze on food throughout the day
___ Pack food in cheeks
___ Picky with textures (which?)_____
___ Difficulty swallowing pills
___ Choking or gagging on food or water

Breathing Issues
___ Trouble breathing through the nose
___ Mouth open / mouth breathing during the day
___ Tonsils or adenoids removed previously
___ Sinus issues or sinus surgery
___ Teeth extracted for braces
___ Jaw surgery in past

Sleep Issues
___ Sleep in strange positions
___ Move around a lot at night
___ Wake easily or often
___ Poor quality sleep
___ Wake up tired and not refreshed
___ Sleep appliance or CPAP needed at night
___ Grind teeth while sleeping
___ Sleep with mouth open
___ Snore while sleeping (how often) _____
___ Gasp for air or stop breathing (sleep apnea)

Other Related Issues
___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Prolonged thumb sucking
___ Ear tubes previously or lots of ear infections
___ Reflux (if so, medication?) _____
___ Constipation
___ Hyperactivity / inattention
___ Stress or anxiety
___ Trouble or pain with kissing / intimacy
___ Don't hold chiropractic adjustments well
___ Not flexible / can't touch toes

Anything Else We Need to Know:

Physician _____

Myofunctional Therapist _____

Who referred you to us? _____

Doctor's Signature _____