Patient Intake - Evaluation

Name:_____Age:_____ D.O.B_____ Date____/____/_____

Address: _____ Phone _____Cell_____

Profession or School_____Work Phone_____

Mother (profession and cell)_____

Father (profession and cell) _____

Siblings: (names/ortho /therapy history)
_____

Referral: _____ Previous Therapy: _____

Ortho History:_____

Current Ortho:_____

Medical History: Infancy to Current :

Medications:_____

Pills: (Swallowing) _____ Gag: _____

Breathing: _____ Allergies:_____ T&A:_____

Sinus:_____ Sore Throat:_____Colds_____

Ears: Ache: _____ Ringing: _____Headaches: loc: _____Frequency:_____

Dental History:_____

Gingival Condition: _____TMD: _____pain:_____ Sounds_____Deviation___

Back / Leg Aches/Neck pain _____ Feet/Hands Cold:_____Eye
Pain/Pressure:_____

Childhood Diseases:

_____Vaccinated_____

Surgery and date_____

_____

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Sucking Habits: Thumb _____ Finger_____ Blanket_____

Clothing:_____ Cheek:_____ Tongue:_____

Pens/pencils:_____

Nail Biting:_____ Clenching:_____ Leaning:_____ Lip-Licking:_____

Gum: _____ Smoke:_____ Other_____

Eating: Messy_____ Speed_____ Gulp:_____ Hiccups:_____

Gas:_____ Stomach Ache/Bloating: _____Drooling

day_____Night_____

Nutrition:

Breakfast _____

Lunch: _____

Dinner: _____

Activities:

Sports:_____ Extracurricular: _____ Hrs/Day____

Musical Instruments_____

Injuries:_____ When/Where: _____

Sleep: _____ Tired_____ Waking up/ Bathroom_____

Snore_____ Frequency:_____ Sleep Study_____

Results:_____ Neck Circumference _____SDB_____

Mallampati Score: 1_____ 2 _____ 3 _____ 4 _____ Comments: _____

Mentalis: Over dev./ Normal _____ Masseter: (pal.)

_____Symmetry_____

Diastema: _____ Rugae: _____ (Sharp/Rounded) Rosenthal

Test_____

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Palate: Size _____Shape:_____

Frenum: Labial:_____Lingual_____

Comments:_____

Oral Posture: _____ Lips Apart or Seal_____Smile_____
Lips: Flaccid _____Dry_____ Dimension_____
Tongue: Rest:_____ Size: _____Movement:_____
Tonsils classification_____

Functional Speech: _____ Lisp:_____S_____R_____

Interdental._____ Lateral:_____ Needs Referral to SLP_____

Other:_____

Functional Posture assessment_____FHP_____Eating_____

Sitting_____Walking_____Lordosis_____

Orofacial Muscle Activation during Swallow	Masseter	Tongue Thrust
Liquids_____	_____	_____
Solids _____	_____	_____
Saliva _____	_____	_____

Tongue Condition: _____ (Scallop/Fissured, etc)
Tongue Range Of Motion: _____Strength OM:_____Accuracy OM:_____
Point:_____
Bowl: _____
Suction_____

Measurements (mm): Classification of occlusion_____
Canine to Canine:_____
Overjet:_____

Patient Intake - Evaluation

Overbite:_____

Open Bite:_____

Cross Bite:_____

Attitude: Patient: _____ Parent:_____

Patient Goals:_____

Recommended Treatment: _____

Goals of Treatment: _____

Comments:

Report to be sent: _____

Payment: _____

Privacy Form signed and handed out_____