***letterhead.TIFFamily Speech Center***

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**Orofacial Myology Case History**

Name Date

DOB Age School/Grade

Address

Email Address

Phone (Home) (Cell)

(Work)

Name of parent/spouse

Referral Physician

Orthodontist Dentist

Feeding History

Nursing, feeding difficulties if any:

Digestive disturbances birth through present

Nursed Y N How Long? \_\_\_\_\_ Supplementary Bottle? Y N

Bottle Y N Type \_\_\_\_ Age Weaned: \_\_\_\_\_

Weak sucking? Y N Other Info

Difficulty swallowing pills? Y N

Messy eater? Y N Noisy eater? Y N

Sucking habits

Current Former

If current, describe methods previously attempted

When did habit begin?

If former, how long did patient have the habit?

Approximate date of cessation of habit

Motor and Speech Development

Age Crawling \_\_\_\_\_Within expectation \_\_\_\_\_\_early \_\_\_\_\_\_late

Age Walking \_\_\_\_\_Within expectation \_\_\_\_\_\_early \_\_\_\_\_\_late

Age First Words \_\_\_\_\_Within expectation \_\_\_\_\_\_early \_\_\_\_\_\_late

Did child babble? Y N

Handedness? R\_\_\_\_\_\_\_\_ L \_\_\_\_\_\_\_\_

Languages exposed to? Fluency level

Medical

Serious illnesses, injuries, hospitalizations Y N Describe

Allergies Y N

Tonsils/Adenoids Y N

Ear infections Y N

Who first noticed orofacial myology problem and when?

What are your present concerns and expectations?

Any further comments or concerns: