Pediatric OMD Intake

Date: ________________

Personal Information:

Child's Name: ______________________________________

Child's Address: ____________________________________

City: _____________________ State: ______ Zip: _________

Birth date: ________________ Age: _______ Gender: M F

Child's Home Phone: _______________________________

Mother's Name: ___________________________________

Mother's Cell Phone: _______________________________

Mother's Email: ___________________________________

Father's Name: ___________________________________

Father's Email: ____________________________________

Referred By: _______________________________________

Dental Information:

Dentist's Name: ____________________

Phone: ___________________________

Orthodontist's Name: ________________

Phone: ____________________________

Educational Information:

School District: _____________________

Home School: ______________________

Services Received (circle)

PT OT Speech Resource Room

Dental History:

Has your child had any teeth extracted? Yes No

How many teeth have been extracted and why? ____

Has you child had palate expansion? Yes No Date of Expansion: ________________

Are braces being considered? Yes No Needs Has Top Bottom

Does your child wear a dental appliance? Yes No

Purpose of Appliance: ____________________________________

Speech History:

Has your child ever had speech therapy? Yes No

Did your child's speech improve with therapy? Yes No

If not, what concerns do you have? ____________________________

Who was your child's speech pathologist? _______________________

Has the dentist or orthodontist ever expressed concerns regarding your child's speech or tongue placement? Yes No

Birth and Medical History:

Please provide the following information as it relates to the infant and child history

Breast Fed, Duration/Complications: ___________________________________

Bottle Fed, Duration/Complications: ___________________________________

Pacifier Use, Until What Age/Frequency: ________________________________

Thumb/Digit Sucking, Until What Age/Frequency: __________________________

Frequent Colds/Weak Immune System, How often: ________________________

Tonsillectomy, Date/Results: ____

Adenoidectomy, Date/Results: ______________________________________

Seasonal Allergies, Describe: ____

Allergies/Intolerances to Food, Describe: ______________________________

Head or Neck Surgeries: ____

Abnormal Sleep Patterns: ____

GERD/Acid Reflux, Treatment: _______________________________________

Sleep Apnea: Yes No Snoring: Yes No

Other Illnesses: ____

Sucking Habits:

My child sucks/sucked (circle all that apply): Fingers Thumb Tongue

Was sucking noted in the womb? Yes No

Does your child currently have sucking habits? Yes No If not, when did the habit end? ____________

What triggers does/did your child have for sucking (circle all that apply)?

Stuffed Animal Blanket Hair Boredom Fatigue Fear Punishment Anxiety Car Rides TV

Homework Other: _________________________________

When does/did the habit occur? Day Night School

Have any techniques been tried to eliminate sucking habits? Yes No

If so, what technique were tried and with what results? ________________________________

Have suggestions been provided regarding elimination of the habit? Yes No

What were the suggestions and were they helpful? ____

Eating and Drinking Habits:

Please provide as much information as possible regarding the way your child receives, chews, and swallows food and liquids.

My child is a (circle all that apply):

Slow Eater Typical Eater Fast Eater Noisy Eater

My child (circle all that apply):

Gulps Food Chews With Mouth Open/Lips Apart Takes Large Bites

Doesn't Chew Thoroughly Burps After Eating Eats Only Soft Foods

Has Upset Stomach Following Eating Washes Food Down Leaves Crumbs on Plate/Table/Floor

Sticks Out Tongue When Eating

Please provide as much information as possible regarding the way your child drinks.

Is the tongue visible when drinking? Yes No

Does your child reach with tongue to guide liquids? Yes No

Puffs cheeks when drinking? Yes No

Makes facial grimaces when drinking? Yes No

Burps after drinking? Yes No

Evaluation and Treatment History:

Please list any evaluations or therapies that your child has had and their outcomes (i.e. speech, occupational, physical therapy, etc)

Evaluation/Therapy Dates Outcome

____

____

Has your child ever been diagnosed by a physician, neurologist, or psychologist as having any type of neurological impairment or syndrome? Yes No If yes, please explain: _______________________________

____

Does your child take any medications or supplements?

Medication Condition

____

____

____

I give permission for photos to be taken of ________________________________ to be used for educational purposes only. (please print)

_______________________________________ (please print) ___________________

Patient/Parent or guardian if patient is a minor Date

_______________________________________ (signature)

Patient/Parent or guardian if patient is a minor

*The following is to be signed in the office on the day of the visit

The Notice of Privacy Practices form was made available to me and I understand in what ways my Protected Health Information (PHI) may be used.

______________________________________(patient name printed)

_______________________________________(signature) ______________________________

Patient/Parent or guardian if patient is a minor Date