NOLAN
Speech and Language Center

Adult OMD Questionnaire

Personal Information:

Date: ___________

Name: ____

Address: ____

City: __________________ State: ______ Zip: _________

Birth date: ___________ Age: ______ Gender: M F

Home Phone No. ( ) ___________________________

Cell Phone No. ( ) ____________________________

Referred By: _______________________________________

Interested in appointment reminders? Email Text

Dental Information:

Dentist's Name: ____

Address ____

Phone: _________________ Email:________________________________

Website:____

Orthodontist's Name: ____

Address ____

Phone: _________________ Email:________________________________

Website:____

Healthcare Provider Information:

Name: ____

Address: ____

Phone: ____

Website: ____

Speech History:

Have you ever had speech therapy? O yes O no

What sounds did you have help producing?

Did your speech improve with therapy? O yes O no

If not, what concerns do you have?

Has a dentist or orthodontist ever expressed concerns regarding your speech or tongue placement? O yes O no

Describe their concerns:

Medical History:

Please provide us with information as it relates your health history.

- O Frequent Colds / Weak Immune System, How Often:___________
- O Ear Aches / Ear Infections, How Many: _____________________
- O P.E. Tubes /Number of Times:______________________________
- O Snoring
- O Hearing Eval, Date/Results: _______________________________
- O Adenoidectomy, Date / Results: ____________________________
- O Frequent Sore Throats / Tonsillitis / Strep Throat
- O Tonsillectomy, Date / Results:______________________________
- O Seasonal Allergies, Describe:

- O Allergies / Intolerances to Foods, Describe:
- O Head or Neck Surgeries
- O Abnormal Sleep Patterns
- O GERD / Acid Reflux, Treatment:________________________
- O Epilepsy
- O Sleep apnea
- O Other Illnesses:
- O Vision Eval, Date/Results:

Name: ___________________________ Date: _________

Eating and Drinking Habits:

Please provide as much information as possible regarding they way you receive, chew, and swallow food and liquids.

I am a (Check all that apply):

- O Slow Eater
- O Typical Eater
- O Fast Eater
- O Noisy Eater

I (Check all that apply):

- O Gulp Food
- O Chew With Mouth Open/Lips Apart
- O Take Large Bites
- O Don't Chew Food Thoroughly
- O Burp After Eating
- O Eat Only Soft Foods
- O Get Upset Stomach Following Eating
- O Wash Food Down
- O Leave Crumbs on Plate/Table/Floor
- O Stick Out Tongue When Eating

Please provide as much information regarding the way you drink.

- O Tongue Visible When Drinking
- O Reach with Tongue to Guide Liquids
- O Puff Cheeks When Drinking
- O Make Facial Grimaces
- O Burp After Drinking

Dental History:

Have you had any teeth extracted? O yes O no

How many teeth have been extracted and why?

Have you had a palate expansion? O yes O no *Date of expansion:________*

Are braces being considered? O yes O no O needs O has O top O bottom

Do you wear a dental appliance? O yes O no

Purpose of appliance:____

Other pertinent dental information:

Sucking Habits:

Please answer the following questions as it pertains to your sucking behaviors

I sucked (check all that apply): O fingers O thumb O tongue

Was sucking noted in the womb? O yes O no

Do you currently have sucking habits? O yes O no *If no, when did the sucking habits end?*_______________________________________

What triggers does/did you have for sucking (check all that apply)?
O pillow O blanket O hair O boredom O fatigue O fear
O anxiety O car rides O T.V. O other, explain:_____________________

When does/did the sucking occur (check all that apply)? O day O night O work

Have any techniques been tried to eliminate the sucking habits? O yes O no

If yes, what techniques were tried and were they successful? O yes O no

____

Have suggestions been provided regarding elimination of the habit? O yes O no

What were their suggestions and were they helpful?

Evaluation and Treatment History:

Please list any evaluations or therapies that you have had and the outcomes (i.e. speech, occupational, or physical therapy, neurological examination, MRI, etc.)

Evaluation/Therapy	Dates	Outcome

Please list any additional care or relative services that you have received:

____
____
____

Have you ever been diagnosed by a physician, neurologist, or psychologist as having any type of neurological impairment or syndrome?__________. If yes, please explain:

Do you take any medications, supplements or vitamins?

Medication	Amt/How Often (i.e. 15mg/2x day)	Condition (i.e. ADHD, Seizures)