NOLAN
Speech and Language Center
Specializing in Orofacial Myofunctional Disorders

Pediatric OMD Intake

Personal Information:

Date: _____

Child's Name: _____
Child's Address: _____
City: _____ State: _____ Zip: _____
Birth date: _____ Age: _____ Gender: M F
Child's Home Phone No. ( ) _____
Mother's Name: _____
Mother's Cell Phone No. ( ) _____
Mother's E-mail: _____
Mother's Occupation: _____
Father's Name: _____
Father's Cell Phone No. ( ) _____
Father's E-mail: _____
Father's Occupation: _____
Alternate Phone: ( ) _____
Referred By: _____

Dental Information:

Dentist's Name: _____
Address _____
Phone: _____ Email:_____
Website:_____

Orthodontist's Name: _____
Address _____
Phone: _____ Email:_____
Website:_____

Developmental Milestone Information:

Please indicate the approximate age at which your child began to do the following:

Rolled Over: _____
Sat unsupported: _____
Crawled: _____
Stood next to things: _____
Stood Alone: _____
Walked along furniture: _____
Walked: _____

Used Spoon: _____
Feed Self: _____
Drank from cup alone: _____
Dressed Self: _____
Toilet Trained: _____
Spoke Single words: _____
Spoke Phrases: _____

Educational Information:

School District: _____
Home School: _____
Grade: _____
Current Educational Program: _____ Regular _____ Special
Does your child have: _____ IEP _____ 504 Plan
What is your child's eligibility? *Circle*
SLI LD ASD ECDD EI Other: _____
Services Received? *Circle*
PT OT Speech Resource Room

Speech History:

Has your child ever had speech therapy? O yes O no
What sounds did your child have help producing? _____
_____
Did your child's speech improve with therapy? O yes O no
If not, what concerns do you have? _____
Is your child still receiving speech therapy? O yes O no
If not, when were services discontinued? _____
Has the dentist or orthodontist ever expressed concerns regarding your child's speech or tongue placement? O yes O no
Describe their concerns: _____
_____
What is the name of your child's Speech Pathologist: _____

Birth and Medical History:

Please provide us with information as it relates to the pregnancy, infant, and child history.

- O Gestational Age:_____ Birth Weight: _____
- O Caesarian Birth/ Natural Birth, Duration of Labor: _____
- O Birthing Complications, Describe:_____
- O Was Baby discharged with Mom? _____
- O Difficulty Breathing, Describe:_____
- O Breast Feed, Duration / Complications: _____
- O Bottle Feed, Duration / Complications:_____
- O Pacifier Use, Until What Age /Frequency:_____
- O Thumb / Digit Sucking, Until What Age / Frequency:_____
- O Frequent Colds / Weak Immune System, How Often:_____
- O Ear Aches / Ear Infections, How Many: _____
- O P.E. Tubes /Number of Times:_____
- 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 _____ Snoring _____
- O Other Illnesses: _____
- O Vision Eval, Date/Results: _____

Child's Name: _____ Date: _____

Eating and Drinking Habits:

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

My child is a (Check all that apply):

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

My child (Check all that apply):

- O Gulps Food
- O Chews With Mouth Open/Lips Apart
- O Takes Large Bites
- O Doesn't Chew Food Thoroughly
- O Burps After Eating
- O Eats Only Soft Foods
- O Has Upset Stomach Following Eating
- O Washes Food Down
- O Leaves Crumbs on Plate/Table/Floor
- O Sticks Out Tongue When Eating

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

- O Tongue Visible When Drinking
- O Reaches with Tongue to Guide Liquids
- O Puffs Cheeks When Drinking
- O Makes Facial Grimaces
- O Burps After Drinking

Dental History:

Has your child had any teeth extracted? O yes O no

How many teeth have been extracted and why? _____

_____

Has your child had 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

Does your child 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 child's sucking behaviors

My child sucks/sucked (check all that apply): O fingers O thumb O tongue

Was sucking noted in the womb? O yes O no

Does your child currently have sucking habits? O yes O no *If no, when did the sucking habits end?*_____

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

O pillow O stuffed animals O blanket O hair O boredom O fatigue O fear
O punishment O anxiety O car rides O playing inside O playing outside
O T.V. O homework O other, explain:_____

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

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 your child has had and their 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 your child has received:

_____

_____

_____

Has your child ever been diagnosed by a physician, neurologist, or psychologist as having any type of neurological impairment or syndrome?_____. If yes, please explain: _____

_____

_____

Does your child take any medications, supplements or vitamins?

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

_____

_____

_____