Chris Zombek BSDH, COM®
Email: chriszombek@innovativemyo.com
Please fill out and send to email 1 week prior.
Questions: 410-746-4887

Medical History

Name_________________________________ Date ____________________

Myofunctional therapy's concentration is usually dealing with the face and mouth however, the head is connected to the body so, a lot of health issues you may have and medicines you take can manifest and affect either the mouth or the body. The mouth, head, neck and body's interrelation are important.
Thank you for taking the time to answer all questions the best you can.

Please give the reason for coming to Innovative Myo: ________________________________
____

Are you presently under the care of a physician ○ Yes ○ No
If yes, please explain:
____
____

Date of last medical exam____

Blood work done: ______Yes _____ NO Any findings: ? ○ Yes ○ No

If yes please explain____
____

Have you been hospitalized or any operations in the last 5 years? ○ Yes ○ No

If yes please explain:
____
____

Have you ever had any serious head, neck or pelvis injuries: ? ○ Yes ○ No

If yes please explain: ____

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What medications, vitamins, or supplements are you taking currently:
List: ____
____

Any neurological disorders? ○ Yes ○ No
If yes please list____

Are you a smoker or history: ○ Yes ○ No

If yes how often: ____

Are you a drinker or have a history: ○ Yes ○ No

If yes how often: ____

Present or history of substance abuse: ○ Yes ○ No

Airway

Present or past problems or operations of any of the below check please:

- ☐ Ever seen an ENT
- ☐ Tonsils ☐ removed
- ☐ Adenoid ☐ removed
- ☐ Nasal turbinate's ☐ removed
- ☐ Nasal obstruction of any sort
- ☐ Deviated septum
- ☐ Recurrent sinus infections
- ☐ Recurrent sinus pain
- ☐ Chronic colds
- ☐ Chronic cough
- ☐ Ear infections (recurrent or history of tubes, hearing loss) **which**______________
- ☐ Asthma (how is it induced) ____
- ☐ Mouth breath during the day
- ☐ Problem drooling during: ☐ Day or ☐ Night or ☐ Don't know
- ☐ Trouble breathing through nose
- ☐ Other ____

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Allergies

Have you had or have any allergies and have to take medications: ○ Yes ○ No

If yes please list: ____

Food Allergies: ○ Yes ○ No

If yes please list: ____

Environmental Allergies: ○ Yes ○ No
If yes please list: ____

Have you ever been tested for allergies? ○ Yes ○ No
If yes, with whom: ______________________ Any Shots or Meds : ○ Yes ○ No

Adult Sleep /Airway (13 years and older)

Do you breathe through your mouth at night or wake up with dry mouth?
○ Yes ○ No ○ Don't know

Do you snore while sleeping?
○ Yes ○ No ○ Don't know
☐ Loud ☐ Quietly

Do you stop or pause your breathing while sleeping?
○ Yes ○ No ○ Don't know

Do you easily get tired or fall asleep during the day?
○ Yes ○ No ○ Don't know

Do you have a hard time concentrating during the day?
○ Yes ○ No ○ Don't know

Do you use sleep medication? ○ Yes ○ No ○ Don't know

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Have you ever fallen asleep driving? ○ Yes ○ No ○ Don't know

How long does it take for you to fall a sleep at night? ______________________________

Wake up during the night? ○ Yes ○ No
What for? _____________________________ How many times? ________________________

Do you feel unrefreshed or tired in the morning despite sleeping all night?
○ Yes ○ No

Do you awake with headaches or get headaches throughout the day? ○ Yes ○ No
How often? ____

Do you awake through the night choking or gasping for air? ○ Yes ○ No

Do you sweat a great deal while sleeping? ○ Yes ○ No

Do you move a lot in your sleep? ○ Yes ○ No
Restless leg during the night? ○ Yes ○ No

Do you wear a c-pap, bi-pap- or other? ____

Sleep Hygiene:
Typical Sleeping position: ☐ back ☐ side ☐ stomach ☐ head elevated

☐ Sleep alone
☐ Pets sleep with me
☐ Watch TV in bed prior to sleep
☐ Drink prior to bedtime
☐ Work or study in bed
☐ Drink alcohol before bed
☐ Snack before bed
☐ Use of the electronic device while in bed

Have you had a sleep test? ○ Yes ○ No
If so at home or in facility? ____
Results? ____
Do you have a copy? ○ Yes ○ No

Trouble Breathing through your nose night? ○ Yes ○ No

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Child Sleep/Airway

While sleeping does your child
☐ Snore - ☐ Always ☐ Sometimes
☐ Break or pause while breathing
☐ Sleep with their mouth open
☐ Sleep on their stomach
☐ Demonstrate restless or agitated sleep
☐ Demonstrate abnormal head postures (hyper-extend)
☐ Breath heavy at night

Does your child occasionally wet the bed, sleepwalk, or have night terrors?
O Yes O No O Sometimes O Don't know

Does your child have a hard time waking up in the morning? O Yes O No
Does your child have dry mouth in the morning or bad breath? O Yes O No
Does your child have headaches in the morning? O Yes O No

Does your child have on going sleepiness throughout the day? O Yes O No

Does your child's teacher report behavior issues, sleepiness at school? O Yes O No

Does your child have any growth issues? O Yes O No

Does your child have attention deficit problem, learning impairment, listening problems?
If yes, please explain

____

____

Does your child have an IEP? O Yes O No If yes, give details

____

____

Does your child fidget with hands, squirm, or other objects? O Yes O No

Does your child often act out? O Yes O No
Explain? ____

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Is your child's pillow wet in the morning? ○ Yes ○ No ○ Don't Know

Have you noticed that your child has difficulty breathing during day or with a lot of effort with sports? ○ Yes ○ No ○ Don't Know

Does your child easily fatigue after exercising? ○ Yes ○ No ○ Don't Know

Do your child keep their mouth open while watching TV or using the computer?
○ Yes ○ No ○ Don't Know

Does your child demonstrate poor posture while sitting or standing?
○ Yes ○ No ○ Don't Know

Dental History

Date of last dental exam? ______________________________

Cavities a lot growing up? ○ Yes ○ No
Accidents or injury to teeth? ○ Yes ○ No
Extensive dental work? ○ Yes ○ No
Late eruption of teeth in childhood? ○ Yes ○ No ○ Don't Know
Missing adult teeth (congenital)? ○ Yes ○ No

Extraction of teeth? ○ Yes ○ No
If yes, please state which ones: ______________________________

Extra teeth? ○ Yes ○ No

Is there any grinding of the teeth? ○ Yes ○ No
☐ Day ☐ Night ☐ Day and Night

Is there any facial pain? ○ Yes ○ No
☐ Left side ☐ Right side
☐ Day ☐ Night ☐ Day and Night

Do you have difficulty opening or closing your mouth or while chewing?
○ Yes ○ No

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Jaws sore upon waking? ○ Yes ○ No

Do you wear a bite guard? ○ Yes ○ No
Upper or Lower? ______________________ How Long? ______________________

Orthodontic History

Phase I
☐ Expander
☐ Head gear
☐ Myobrace or Healthy Start

Phase II
☐ Braces Upper and Lower
☐ Invisalign
☐ Alf or DNA appliance
☐ Other ____
☐ Adult or ☐ Child

How long in braces? ________________ How many rounds of braces? ____________

Any jaw surgery? ○ Yes ○ No

Habits

Do you have a history or presently of the following?

☐ Thumb sucking How Long? ______________
☐ Finger sucking How Long? ______________
☐ Tongue Sucking How Long? ______________
☐ Nail biting How Long? ______________
☐ Other: ____
(example: Blanket sucking, hair chewing, lip licking, pencil chewing, leaning on hand)

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Feeding / Nutritional History

Are you a messy when eater chew with mouth open? ○ Yes ○ No

Were their feeding difficulties growing up? ○ Yes ○ No
If yes please explain:
____
____

Bottle feed? ○ Yes ○ No How long? __________ Type of nipple ____________

Breast feed? ○ Yes ○ No How long? __________

Sippy Cup? ○ Yes ○ No How long? __________

Does patient have a history?

- ☐ Reflux
- ☐ Gags easily on food
- ☐ Can't swallow a pill
- ☐ Finicky eater
- ☐ Messy eater
- ☐ Food Allergies
- ☐ Drink a lot when eating
- ☐ Texture aversion
- ☐ Chokes easily
- ☐ Noisy eater or Noisy drinker

Avoids these foods:
____

Likes foods:
____

Other digestive issues:
____

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Developmental/Speech History

Any birthing issues? ○ Yes ○ No If yes, please explain:

____

____

(examples: pre-term, C-section, breech, forceps)

Use of pacifier? ○ Yes ○ No How long: ____________________

Did you meet milestones for crawling, walking, talking were normal? ○ Yes ○ No

Car or carrier seat used a lot? ○ Yes ○ No ○ Don't Know

Was speech delayed? ○ Yes ○ No ○ Don't Know

Speech problems? ○ Yes ○ No Which letters? ______________________

Stuttering? ○ Yes ○ No

What do you hope to achieve from this evaluation? ______________________________

____

Describe the problem you've experiencing? ______________________________

____

What do you think has caused the problem? ______________________________

____

What have you tried to fix the problem? ______________________________

____

I understand the above information is necessary to provide me with Orofacial Myofunctional Therapy in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the therapist of any change in my health or medication.

Patient Signature: ______________________________

Parent / Guardian Signature: ______________________________

Date: ____________________