

 Evaluation Case History Form-18+

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Address: | Home:Cell: |
| Referral Source: | Email: |
| Age/Occupation | Age/Occupation |
| Whole lives in the home? | Primary Care MD name and address: |
| If student, please list college /school: | Dentist name and address: |
| Languages Spoken: | List any History of Medical or Educational Diagnoses in the immediate family: |

Briefly, what is the reason(s) for this evaluation?

Use 3-5 words to describe your goals in this office:

**Pediatric History**

Were there any complications during your mother’s pregnancy? \_\_\_\_yes \_\_\_\_no (if yes explain)

Did your mother carry full term? \_\_\_\_yes \_\_\_\_no (if no explain)

Were there problems during delivery? \_\_\_\_yes \_\_\_\_no (if yes explain)

Did you require any special care after delivery? \_\_\_\_yes \_\_\_\_no (if yes please explain)

Were there any developmental concerns? \_\_\_\_\_yes \_\_\_\_\_\_no

Did/do you have a global diagnosis (Down syndrome, autism etc.)? \_\_\_\_\_yes \_\_\_\_\_\_no

If yes, please explain:

Does/did you receive early intervention? \_\_\_\_\_yes \_\_\_\_\_\_no

Do/did you have an IEP? \_\_\_\_\_yes \_\_\_\_\_\_no

**Medical History**

Does you have (or had) any of the following issues?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Frequent colds or congestion |  | Bronchitis |
|  | Strep |  | Tongue/lip/cheek tie(s) |
|  | Middle ear infections |  | Asthma |
|  | Food allergies (list) |  | Other allergies (list) |
|  | GI issues |  | Reflux/GERD |
|  | Trouble sleeping |  | Dental problems |
|  | Vocal hoarseness |  | Weight issues |
|  | Endocrine issues |  | Cardiac issues |
|  | Digestion problems  |  | Waking frequently at night |
|  | Autoimmune issues |  | Sleep apnea |
|  | Dry mouth or bad breath |  | Snoring |
| Other |   |

Surgical history? (please explain)

Medications?

**Dental History**

How often do you see the dentist?

Orthodontist? \_\_\_\_yes \_\_\_\_no/ If yes, explain past or current treatment:

Periodontist? \_\_\_\_ yes \_\_\_\_ no /If yes, explain past or current treatment:

Does the dentist have any concerns about structure? If yes, explain past or current treatment:

**Feeding/Swallowing History**

Did you have feeding issues as a child? \_\_\_yes \_\_\_no

Are there any concerns about nutritional status? \_\_\_\_yes \_\_\_\_no

Do you have any concerns about your eating habits or skills? \_\_\_\_yes \_\_\_\_no

Have you had a swallow study? (If so please attach the results) \_\_\_\_yes \_\_\_\_no

How were you fed in the first year of life? Breast\_\_\_\_ Bottle\_\_\_\_\_ Both \_\_\_\_\_ unknown ­­\_\_\_\_

If you experience any challenges chewing or swallowing, please explain:

At what age did you stop breast or bottle feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_

Any special or restricted diet (i.e., gluten free, dairy free)? \_\_\_\_yes \_\_\_\_no

If so, please describe:

Do you have a self- limited diet (picky eating)? \_\_\_\_yes \_\_\_\_no

If so, please describe:

Do you get indigestion after eating? \_\_\_\_often \_\_\_\_ never \_\_\_\_ sometimes

Which foods trigger indigestion?

Do you have concerns about your weight? \_\_\_\_ too low \_\_\_\_ too high \_\_\_\_ none

Do you binge eat? \_\_\_\_ yes \_\_\_\_ no

Do you drink alcohol? \_\_\_\_socially \_\_\_\_often \_\_\_\_ never

Do you eat from stress? \_\_\_\_ yes \_\_\_\_ no

Are you currently on a diet? \_\_\_\_yes \_\_\_\_ no

Please chart what you eat (item and amount), in the following *Five-Day Baseline Diet*:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 |
| Breakfast |  |  |  |  |  |
| Snack |  |  |  |  |  |
| Lunch |  |  |  |  |  |
| Snack |  |  |  |  |  |
| Dinner |  |  |  |  |  |
| snack |  |  |  |  |  |

**Sensory:**

List any sensory issues you have/had challenges with (ex. Dislike loud noises):

Do/did you engage in any self-stimulatory behaviors? (ex. Rocking, humming etc.)

**Oral-Motor/Oral Habits:**

Do you have a history of drooling? \_\_\_\_yes \_\_\_\_no

Do you drool at night? \_\_\_\_yes \_\_\_\_ no

Do you smoke \_\_\_\_ yes \_\_\_\_ no

Do you suck your thumb or digits? \_\_\_\_yes \_\_\_\_no

Do you bite your nails? \_\_\_\_ yes \_\_\_\_ no

Did you use a pacifier after the first year? \_\_\_\_yes \_\_\_\_no If so, for how long?

Do you suck your tongue, chew the soft tissue in your cheeks or have any other oral habit (please explain)? \_\_\_\_ yes \_\_\_\_ no

Did/do you exhibit open mouth posture and/or mouth breathing? \_\_\_\_yes \_\_\_\_no

**Speech**

 Have you ever been in speech therapy and if so, why? \_\_\_\_ yes \_\_\_\_ no

Do you have any concerns about sound production? \_\_\_\_ yes \_\_\_\_no

If yes, what sound (s) do you have difficulty producing (circle/highlight sounds that apply)?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| B | M | P | W | T | D | N | L | K |
| G | H | R | Sh | Ch | J | S | Z | J |
| R blends | L blends | S blends | K blends | TH | VOWELS |  |  |  |

**Therapy**

Has you been seen by for…

feeding therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist and why:

occupational therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist and why:

orofacial myofunctional therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist and why:

physical Therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist:

**Social History:**

Do you have any anxiety or shame because of your challenges you seek help with?

What do you enjoy?

What do you do to de-stress?

Describe yourself in 5-10 adjectives:

ADDITIONAL INFORMATION: (feel free to provide additional reports).