Creative Communication for Kids
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Today's Date: _____ Form Completed By: _____

Supplemental Case History
For Tongue Thrust/Myofunctional Therapy

CHILD'S NAME: _____ **Birthdate:** _____

PRIMARY PHYSICIAN NAME: _____
Address: _____
_____
Phone: _____

ORTHODONTIST NAME (if applicable)**:** _____
Address: _____
_____
Phone: _____

EAR, NOSE, THROAT or ALLERGIST NAME (if applicable)**:** _____
_____
Address: _____
_____
Phone: _____

DENTAL HISTORY
Describe previous and/or current orthodontic treatment:
_____
_____
_____
_____

Date orthodontia treatment began: _____

Describe any dental accidents; include dates: _____
_____
_____
_____

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DEVELOPMENTAL HISTORY

1. Does your child *currently* suck his/her thumb or finger? Please describe (e.g. only during sleep, when stressed, while watching t.v., etc): _____ yes _____ no

_____

_____

_____

2. Did your child *previously* suck his/her thumb? _____ yes _____ no

3. Does your child usually breathe through his/her nose or through the mouth during activities such as t.v. watching, reading, writing? _____ nose _____ mouth

4. Has your child ever been diagnosed with breathing difficulties, perhaps due to enlarged tonsils or enlarged adenoids? Please describe: _____ yes _____ no

_____

_____

5. Does the tongue thrust affect your child's articulation of speech sounds? Please describe: _____

_____

_____

6. Does the tongue thrust affect your child's chewing and/or swallowing? Please describe: _____

_____

_____

ADDITIONAL COMMENTS

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