PATIENT HISTORY (AIRWAY, TONGUE, POSTURE)

Patient Name: _____ Date of Exam: _____

Parent/Sibling Names: _____Age/DOB: _____

Patient's Main Concern/Reason for Seeking Treatment:

Early Childhood

Bottle fed breast fed not sure difficulty feeding or latching premature birth
tongue-tied or lip-tied as an infant long or difficult labor C-Section
Notes/Other:

Current oral habits? YES/NO
Oral habits in past? YES/NO
Thumb sucking Finger sucking Nail biting prolonged pacifier use
Sucking on clothing/hair/blanket/etc
Notes/Other:
History of ear problems or infections? YES/NO Current ear problems/Infections? YES/NO
Tubes placed? YES/NO
How many rounds of antibiotics?
Tinnitus, vertigo, or other symptoms?
Notes/Other:

Speech Therapy

Has the patient been evaluated by a speech language pathologist? YES/NO
If they were treated, what was the focus of speech therapy?
Does the patient or parent believe that there are current speech concerns? YES/NO
If so, what are they?
"S" sound or lisp "R" or "L" problems general lack of clarity or mumbling voice projection Notes/
Other:

Digestive Problems

Abdominal bloating or cramping belching flatulence acid reflux/heartburn/GERD laryngopharyngeal reflux (LPR) irritable bowel syndrome (IBS) leaky gut small intestinal bacterial overgrowth (SIBO)

What is the frequency of these symptoms? (Daily, weekly, 3x per month, etc)
Notes/Other:

Breathing History and Evaluation

Are allergies present? YES/NO seasonal dust pets/dander other:

Has the patient been formally tested for allergies? YES/NO

What medications do they take for their allergies?

What else do they use to relieve symptoms? (Saline nasal spray, neti pot or rinsing, acupuncture, etc)

Do they have nasal congestion that is not necessarily related to allergies? YES/NO

Do they have a history of asthma or currently have asthma? YES/NO

Do they take medication?

Notes/Other:

Septoplasty or rhinoplasty Turbinate reduction Nasal polyps Nostril collapse (fast inhale) Empty nose syndrome Sinus infections, pressure, headaches, pain Chin implant
Notes/Other:

Head, Neck, and Jaw Pain

Pain: neck shoulders migraines headaches TMJ facial

Frequency?

Pain level (1-10)

NOTES:

Tension: neck shoulders migraines headaches TMJ facial clenching grinding night guard or splint recommended

OTHER/NOTES:

Posture and Bodywork

Forward head posture rolled shoulders slouching
Have you ever worked with a professional on your posture? (PT, OT, yoga, personal trainer). YES/NO
Do you see a chiropractor, physical therapist, massage therapist, cranial osteopath, or any other type?
OTHER/NOTES:

Sleep Disordered Breathing

How many hours of sleep do you get on average? YES/NO
Do you wake up feeling well rested? YES/NO
Do you feel tired during the daytime? YES/NO
Do you experience brain fog, forgetfulness feeling "spaced out"? YES/NO
Do you feel chronically fatigued or run down? YES/NO
Do you experience insomnia? YES/NO

How would you describe your sleep: interrupted restless like a log light sleeper deep sleeper soaked in sweat wake up to use the restroom regularly

Do you mouth breathe or heavy breathe at night? YES/NO
Have you experienced or been diagnosed with any of the following conditions?

Snoring Upper Airway Resistance Syndrome (UARS) Obstructive Sleep Apnea

Has a bed partner ever heard you stop breathing at night? YES/NO
Has a dentist or doctor ever recommended a sleep study? YES/NO
Have you ever had a sleep study? YES/NO
What was your AHI, RDI, OD?

Do you currently have a CPAP or MAD? YES/NO
How often do you wear it?

Airway Evaluation

Has the patient seen an ENT for an evaluation? YES/NO
Has it been recommended to remove the tonsils and/or adenoids? YES/NO
Allergic shiners/venous pooling? YES/NO
Hyperactive? YES/NO
Mouth breath during the day? YES/NO
Frequent headaches in the morning? YES/NO
If so, what part of the head do they start at?

Talks in sleep? YES/NO

Attention deficit YES/NO

Frequent throat infections? YES/NO

If so, how many?

Deviated septum? YES/NO Crease on bridge of nose? YES/NO

Notes/Other:

DO NOT FILL OUT, DONE BY CLINICIAN

Tonsil Grade: 0 I II III removed

Malampatti Score: I II III IV

Orthodontic and Dental

Class II Class III open bite crossbite narrow palate overjet deep bite

history of expansion orthodontic relapse vertical maxillary excess/gummy smile

History of periodontal disease, deep cleaning, recession, or deep pockets? YES/NO

High caries risk? YES/NO

OTHER/NOTES: