Child Assessment Sheet

Patient's Name ______________________________Birthday _____________Age____ Today's Date ______________

Medical issues: _____________________________ Medications taking: ____

Allergies: ___________________________________ Previous clip or release of tongue? __________________(date)

1. Has your child experienced any of the following issues? Please check or elaborate as needed.

Speech
___ Frustration with communication
___ Difficult to understand by parents
___ Difficult to understand by outsiders
___ % Percent of time you understand your child
___ Difficulty speaking fast
___Difficulty getting words out (groping for words)
___ Trouble with sounds (which?)_________________
___ Speech delay (when?)________________________
___ Stuttering
___ Speech harder to understand in long sentences
___ Speech therapy (how long)__________________
___ Mumbling or speaking softly
___"Baby Talk"

Feeding
___ Frustration when eating
___ Difficulty transitioning to solid foods
___ Slow eater (doesn't finish meals)
___ Grazes on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky with textures (which?)_________________
___ Choking or gagging on food
___ Spits out food
___ Other:

Nursing or Bottle-Feeding Issues as a Baby
___ Painful nursing or shallow latch
___ Poor weight gain
___ Reflux or spitting up
___ Unable to hold pacifier
___ Milk dribbling out of mouth
___ Poor Supply
___ Nipple shield required for nursing
___ Clicking or smacking noise when eating
___ Other:

Other related issues
Anything else we need to know:
___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or poppin
___ Headaches or migraines
___ Strong gag reflex

Sleep issues
___ Sleeps in strange positions
___ Kicks and flails around at night
___ Wakes easily or often
___ Wets the bed
___ Wakes up tired and not refreshed
___ Grinds teeth while sleeping
___ Sleeps with mouth open
___ Snores while sleeping (how often) _____________
___ Gasps for air or stops breathing (sleep apnea)
___ Mouth open /mouth breathing during the day
___ Tonsils or adenoids removed previously
___ Ear tubes previously
___ Reflux (medicated or not)
___ Hyperactivity / Inattention
___ Constipation

Pediatrician ____

Speech Therapist _______________________________________

Who referred you to us? ________________________________

Doctor's Signature ____