

TONGUE-TIE TEAM

CHILD ASSESSMENT SHEET

Today's Date: _____

Patient's Name: _____ Birth Date: _____ Age: _____ Male Female

Primary Care Provider: _____ Chiropractor/PT/CST: _____

Speech/Feeding Therapist _____ Other Therapist/Provider: _____

Medical issues: _____ Allergies: _____

Medications taking: _____

Previous clip of tongue/lip? (when/where) _____

Who referred you to us? _____ How far away do you live? _____

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

<p>SPEECH</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frustration with communication <input type="checkbox"/> Difficult to understand by parents <input type="checkbox"/> Difficult to understand by outsiders <input type="checkbox"/> % Percent of time you understand your child _____ <input type="checkbox"/> Difficulty speaking fast <input type="checkbox"/> Difficulty getting words out (groping for words) <input type="checkbox"/> Trouble with sounds (which?) _____ <input type="checkbox"/> Speech delay (when?) _____ <input type="checkbox"/> Stuttering <input type="checkbox"/> Speech harder to understand in long sentences <input type="checkbox"/> Speech therapy (how long): _____ <input type="checkbox"/> Mumbling or speaking softly <input type="checkbox"/> "Baby Talks" or uses baby voice 	<p>FEEDING</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frustration when eating <input type="checkbox"/> Difficulty transitioning to solid foods <input type="checkbox"/> Slow eater (doesn't finish meals) <input type="checkbox"/> Small appetite / Trouble gaining weight <input type="checkbox"/> Grazes on food throughout the day <input type="checkbox"/> Packing food in cheeks like a chipmunk <input type="checkbox"/> Picky eater/ with textures (which?) _____ <input type="checkbox"/> Choking or gagging on food <input type="checkbox"/> Spits out food <input type="checkbox"/> Won't try new foods <input type="checkbox"/> Constipation <input type="checkbox"/> Reflux (medicated or not) <input type="checkbox"/> Affects family dynamics (can't eat out, etc.)
<p>Nursing or Bottle-Feeding Issues as a Baby</p> <ul style="list-style-type: none"> <input type="checkbox"/> Painful nursing or shallow latch <input type="checkbox"/> Poor weight gain <input type="checkbox"/> Reflux or spitting up <input type="checkbox"/> Gassy (tooted a lot) as baby <input type="checkbox"/> Milk leaked out of mouth / messy eater <input type="checkbox"/> Poor milk supply <input type="checkbox"/> Nipple shield needed for nursing <input type="checkbox"/> Clicking or smacking noise when eating <input type="checkbox"/> Cried a lot / colic as baby <input type="checkbox"/> Other: _____ 	<p>Sleep Issues</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sleeps in strange positions <input type="checkbox"/> Sleeps restlessly (moves a lot) <input type="checkbox"/> Wakes easily or often <input type="checkbox"/> Wets the bed <input type="checkbox"/> Wakes up tired and not refreshed <input type="checkbox"/> Grinds teeth while sleeping <input type="checkbox"/> Sleeps with mouth open <input type="checkbox"/> Snores while sleeping (how often) _____ <input type="checkbox"/> Gasps for air or stops breathing (sleep apnea)
<p>Lip-Tie Issues</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficult or fights to brush top teeth <input type="checkbox"/> Top teeth don't show when smiling <input type="checkbox"/> Gap between two front teeth <input type="checkbox"/> Cavities on front teeth <input type="checkbox"/> Trouble eating from a spoon/ flips spoon over <input type="checkbox"/> Trouble with B,P,M or W sounds 	<p>Other Related Issues</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck or shoulder pain or tension <input type="checkbox"/> TMJ Pain, clicking, or popping <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Strong gag reflex <input type="checkbox"/> Prolonged thumb sucking / pacifier use. <input type="checkbox"/> Mouth open /mouth breathing during the day <input type="checkbox"/> Tonsils or adenoids removed previously <input type="checkbox"/> Ear tubes previously / lots of ear infections <input type="checkbox"/> Hyperactivity / Inattention

Doctor's Signature _____