MOUNTAIN KIDS
TONGUE & LIP TIE CENTER

CHILD

Today's Date: _____

Patient's Name: _____ Patient's Birthdate: _____/_____/_____

Medical Problems

Heart Disease _____ Bleeding Disorders _____ Other _____

Birth Information

____ Male ____ Female Current Weight _____
Birth Weight _____ Birth: VAGINAL C-SECTION
Birth Hospital _____

Any birth complications? YES NO
If yes, please explain _____
_____

Are you currently breastfeeding?____If no, how long since you stopped breastfeeding? _____

Has your child experienced any of the following issues?

Please check all that apply & elaborate as needed.

Speech

___ Frustration with communication
___ Difficult to understand by parents
___ Difficult to understand by outsiders
___ % of time you understand your child
___ Difficulty speaking fast
___ Difficulty getting words out
___ Trouble with sounds (which?) _____
___ Speech delay (when?) _____
___ Stuttering
___ Speech hard to understand in long sentences
___ Speech therapy (how long?) _____
___ Mumbling/Speaking Softly
___ Baby Talk

Feeding

___ Frustration when eating
___ Difficulty transitioning to solid foods
___ Slow eater (doesn't finish meals)
___ Small appetite / Trouble gaining weight
___ Grazes on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky eater/ with textures (which?) _____
___ Choking or gagging on food
___ Spits out food
___ Won't try new foods
___ Other: _____
How long does baby take to eat? _____
How often does baby eat? _____

Nursing/Bottle-Feeding Issues As A Baby

___ Painful nursing or shallow latch
___ Poor weight gain
___ Reflux or spitting up
___ Unable to hold pacifier
___ Milk dribbled out of mouth/messy eater
___ Poor Supply
___ Nipple shield required for nursing
___ Clicking or smacking noise when eating
___ Cried a lot/colic as baby
___ Other: _____

Sleep Issues

___ Sleeps in strange positions
___ Sleeps restlessly (moves a lot)
___ 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/stops breathing (sleep apnea
___ Other: _____

Has your child experienced any of the following issues?

Please check all that apply & elaborate as needed.

Other Related Issues

___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Mouth open/mouth breathing during the day
___ Tonsils or adenoids removed previously
___ Ear tubes previously / lots of ear infections
___ Reflux (medicated or not)
___ Hyperactivity / Inattention
___ Constipation

Anything else we need to know?

Feel free to list it all here:

Pediatrician: _____
Who referred you to us? _____
Speech Therapist: _____
Doctor's Signature: _____

If you have any questions or concerns,
please give us a call any time at:
970.224.3600