**MYOFUNCTIONAL HISTORY**

**Child’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please think of the various stages of your child’s development, considering behavior, which comes to your mind as you answer these questions. The following questions are posed to help in compiling a more complete picture of your child from early infancy to his/her present developmental stage. Please add narrative information, which may also be important in the spaces provided. Thank You.

**Who referred patient for evaluation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Complaint:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Other complaints affecting: (0) not an issue (1) sometimes (2) frequently or always***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Lips ( ) | Tongue ( ) | Sucking ( ) | Chewing ( ) | Swallowing ( ) |
| Breathing ( ) | Speech ( ) | Tongue Frenulum ( )  | Voice ( ) | Hearing ( ) |
| Learning ( ) | Facial aesthetic ( ) | Posture ( ) | Occlusion ( ) | Headache ( ) |
| TMJ clicking ( ) | TMJ pain ( ) | Neck pain ( ) | Shoulder pain ( ) | Jaw range of motion ( ) |
| Other:  |  |  |  |  |

**Breathing Problems**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Annual frequency** | **Treatment** | **Medication** |
| **Frequent Colds\*** | **No** | **Yes** |  |  |  |
| **Throat Problems** | **No** | **Yes** |  |  |  |
| **Tonsils** | **No** | **Yes** |  |  |  |
| **Halitosis** | **No** | **Yes** |  |  |  |
| **Asthma** | **No** | **Yes** |  |  |  |
| **Bronchitis** | **No** | **Yes** |  |  |  |
| **Pneumonia** | **No** | **Yes** |  |  |  |
| **Rhinitis** | **No** | **Yes** |  |  |  |
| **Sinusitis** | **No** | **Yes** |  |  |  |
| **Nasal obstruction** | **No** | **Yes** |  |  |  |
| **Nasal itching** | **No** | **Yes** |  |  |  |
| **Runny nose** | **No** | **Yes** |  |  |  |
| **Sneezing in a row** | **No** | **Yes** |  |  |  |

**\*Frequent colds:** children up to 5 years old – over 12 colds a year

 Between 6 and 12 years old – over 6 colds a year

**Other problems:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep**

|  |  |  |  |
| --- | --- | --- | --- |
| **Restless sleep** |  |  |  |
| **Snoring** |  |  |  |
| **Apnea** |  |  |  |
| **Water intake at night** |  |  |  |
| **Sleeping with mouth open** |  |  |  |
| **Waking up with a dry mouth** |  |  |  |
| **Pain in the face when wake up** |  |  |  |
| **Posture** |  |  |  |
| **Hand resting on the face** |  |  |  |

 **Other problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Oral Habits**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pacifier** | **No** | **Yes** | **Until: \_\_\_\_\_\_\_\_\_\_** |
| **Thumb sucking** | **No** | **Yes** | **Until: \_\_\_\_\_\_\_\_\_\_** |
| **Tongue sucking** | **No** | **Yes** | **Until: \_\_\_\_\_\_\_\_\_\_** |
| **Lip licking** | **No** | **Yes** | **When: \_\_\_\_\_\_\_\_\_** |
| **Bruxism** | **No** | **Yes** | **[ ] day [ ] night** |
| **Grinding** | **No** | **Yes** | **When: \_\_\_\_\_\_\_\_\_** |
| **Nail Biting** | **No** | **Yes** | **When: \_\_\_\_\_\_\_\_\_** |
| **Cheek Biting** | **No** | **Yes** | **When: \_\_\_\_\_\_\_\_\_** |
| **Excessive/drooling** | **No** | **Yes** | **When: \_\_\_\_\_\_\_\_\_** |

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Posture Habits**

|  |  |  |  |
| --- | --- | --- | --- |
| **Lower Lip Sucking** | **No** | **Yes** |  |
| **Mandible Protruding** | **No** | **Yes** |  |
| **Hand resting on chin** | **No** | **Yes** | **[ ] Right [ ]Left** |
| **Head resting on hand** | **No** | **Yes** | **[ ] Right [ ] Left** |
| **Excessive computer use** | **No** | **Yes** | **Posture:**  |
| **Excessive phone use** | **No** | **Yes** | **Posture:**  |

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Speech**

|  |  |  |  |
| --- | --- | --- | --- |
| **Difficult to understand** | **No** | **Yes** |  |
| **Tongue protrusion** | **No** | **Yes** |  |
| **Hoarseness of voice** | **No** | **Yes** |  |

**Any other additional comments or concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**