Untethered
AIRWAY HEALTH & TONGUE-TIE CENTER

First Name: **Last Name:**

Date of Birth: **Today's Date:**

Responsible Party (if someone other than the patient):

Street Address:

City, State, Zip:

Phone: **Email:**

Occupation: **Referred by:**

Physician/Pediatrition Name/ Contact Information:

Other Care Providers

GENERAL MEDICAL HISTORY - Current or Past

- ☐ Sleep Apnea/UARS/Other Sleep Disorders
- ☐ Recurrent Upper Respiratory Infections
- ☐ Recurrent Strep Throat
- ☐ Deviated Septum
- ☐ Nasal Polyps
- ☐ Turbinate Reduction
- ☐ History of Enlarged Tonsils
- ☐ Hyperactivity
- ☐ History of Anxiety
- ☐ History of Depression
- ☐ Middle Ear Issues
- ☐ Myringotomy (ear tubes)
- ☐ Autism
- ☐ Bells Palsy
- ☐ High/Low Blood Pressure
- ☐ Diabetes, A1C:_____
- ☐ Recurrent Sinus Infections
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ TB (Tuberculosis)
- ☐ ADD/ADHD (Attention Deficit Disorder)
- ☐ Airway Surgeries - Nose, Tongue, Other:_____
- ☐ Chronic Nasal Congestion
- ☐ Visual Processing Issues
- ☐ Tonsillectomy: age_____
- ☐ Removal of Adenoids: age_____
- ☐ Recurrent Ear Infections
- ☐ Cancer, Type:_____
- ☐ Auditory Processing Issues
- ☐ Down Syndrome
- ☐ Heart Issues: _____
- ☐ Irregular Heartbeat (Arrhythimia)
- ☐ Asthma
- ☐ Thyroid Problems (Hypo, Hyper)
- ☐ Allergies: to what:_____

Surgeries & Dates: _____

Other/Comments: _____

_____

_____

CURRENT MEDICATIONS – Prescription & Over the Counter Supplements/Meds:

_____

_____

ALLERGIES: _____

Patient's main concern/reason for treatment: _____

_____

PRENATAL HISTORY:

☐ Normal ☐ Drug exposure ☐ Smoking complications ☐ Alcohol exposure

☐ Preeclampsia ☐ Other: _____

BIRTH HISTORY:

☐ Normal (To Term 40 wks) ☐ Early delivery wks: _____ ☐ Complications ☐ C-Section

☐ Extensive labor ☐ Forceps ☐ Preterm labor ☐ Breech ☐ Induction

☐ Torticollis ☐ Other: _____

EARLY FEEDING HISTORY:

☐ Breastfed duration: _____ ☐ Difficulty latching ☐ Sore or bleeding nipples

☐ Pulled off in frustration ☐ Bottle-fed ☐ Other: _____

☐ Acid reflux ☐ Frequent belching ☐ Vomiting ☐ Gagging

☐ Gastro-intestinal discomfort/Distention/Gas/Constipation

☐ Other: _____

Treatment: _____

FINE MOTOR DEVELOPMENT:

☐ Normal (e.g. drawing) ☐ Delayed

GROSS MOTOR DEVELOPMENT:

☐ Normal (e.g. rolling, crawling, walking) ☐ Delayed

NOXIOUS HABITS – Previous or Current:

☐ Finger/s sucking ☐ Current? Age resolved _____

☐ Pacifier Usage ☐ Current? Age resolved _____

☐ Nail biting ☐ Current? Age resolved _____

☐ Trichotillomania ☐ Current? Age resolved _____

☐ Hair twisting ☐ Current? Age resolved _____

☐ Object Chewing ☐ Current? Age resolved _____

☐ Tongue sucking ☐ Current? Age resolved _____

Other: _____

SPEECH THERAPY:

Has the patient been evaluated by 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 ☐

ORAL FAMILY HISTORY:

☐ Ankyloglossia (tongue tie) ☐ No know HX Family member _____

☐ Lip-tie ☐ No know HX Family member _____

☐ Cleft palate ☐ No know HX Family member _____

☐ Orthodontia ☐ No know HX Family member _____

Speech Disturbance? ☐ YES ☐ NO Other: _____

REPORTED CHEWING PATTERNS:

☐ Described as a picky eater ☐ Noisy eater ☐ Audible ☐ Gulping ☐ Messy

☐ Gags easily ☐ Chews w/ lips apart ☐ Facial discomfort ☐ Coughs after meals

☐ Relies on liquids w/ meals ☐ Dental factors resulting in adaptations

☐ Saliva management ☐ Drooling Other: _____

PILL SWALLOWS:

☐ Large pills ☐ WNL ☐ W/ difficulty ☐ Incapable

☐ Small pills ☐ WNL ☐ W/ difficulty ☐ Incapable

☐ Never Attempted pill swallowing Comments: _____

SENSITIVITIES:

☐ Pain sensitivities ☐ Tags/Cloth Textures ☐ Temperatures ☐ Sensitive to touch

☐ Avoids spicy foods ☐ Enjoys spicy foods ☐ Proprioception difficulties

☐ Skin neuralgia Other: _____

REPORTED FOOD AVERSIONS:

☐ All meats ☐ Fibrous meats ☐ Raw vegetables ☐ Fruits ☐ Cooked vegetables

☐ Breads ☐ Textures ☐ Spicy ☐ Can only tolerate soft solids

Other: _____

DIGESTIVE PROBLEMS:

☐ Abdominal bloating ☐ Cramping ☐ Belching

☐ Acid reflux (GERD, Heartburn) ☐ Laryngopharyngeal reflux (LPR)

☐ Irritable bowel syndrome (IBS) ☐ Leaky gut

☐ Small intestinal bacterial overgrowth (SIBO)

What is the frequency of these symptoms? Daily ☐ Weekly ☐ 3x/month ☐

Other: _____

PAIN/TENSION DISORDERS:

☐ Joint/Arthritis ☐ Neck ☐ Muscular pain ☐ Fibromyalgia

☐ Head ☐ Jaw/TMD Pain ☐ Shoulders ☐ Facial

Other: _____

_____

TMJ or facial pain: Pain scale (1-10)_____ Frequency (how often):_____

How do you manage your pain?:

☐ Controlled with OTC medications – Name of medication _____

☐ Controlled with RX by doctor – Name of RX _____

Other control methods: _____

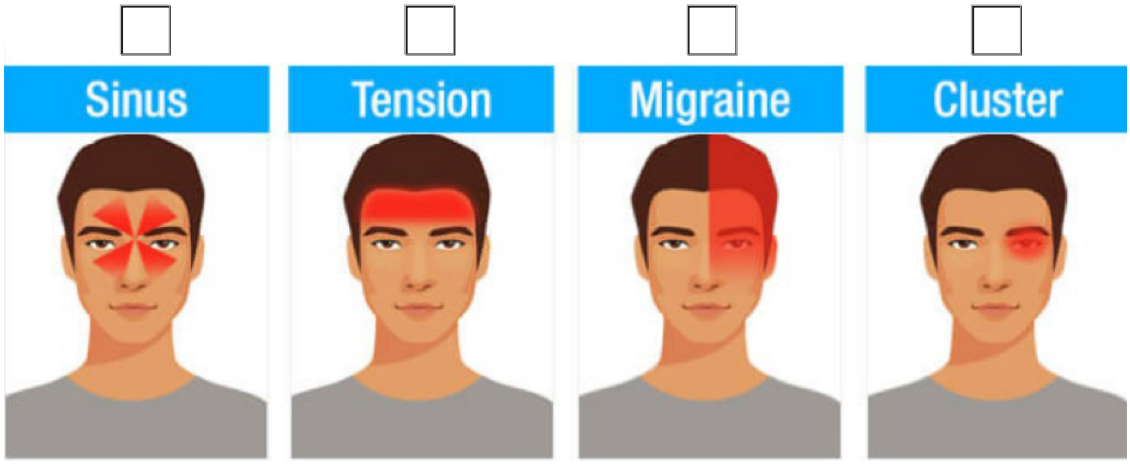
HEADACHES:

☐ Headaches ☐ Migraines

Headache/Migraine pain: Pain scale (1-10) _____ Frequency (how often): _____

How do you manage your pain?:_____

Check headache type:



GENERAL DENTAL HISTORY:

☐ No dental treatment to date ☐ High cavity risk ☐ Gum disease

☐ History of "deep cleaning" ☐ Bleeding gums ☐ Recession ☐ History of gum graft

☐ Primary tooth extractions ☐ Removal of teeth for orthodontictx

☐ Removal of Wisdom Teeth

Other: _____

ORTHODONTIA HISTORY:

- [ ] No orthodontic treatment to date
- [ ] Current orthodontic treatment
- [ ] Phase I orthodontic treatment
- [ ] Orthodontic appliance therapy (PREV/CUR)
- [ ] Previous palatal expander
- [ ] Current palatal expander
- [ ] Orthodontic relapse
- [ ] Head gear [ ] Previous [ ] Current
- [ ] Completed orthodontics
- [ ] Aligner Therapy (ie, Invisalign) [ ] Previous [ ] Current
- [ ] Retainers
- [ ] Fixed (permanent) retainers
- [ ] Removable appliance

Other: _____

POSTURE AND BODY WORK:

- [ ] Forward head
- [ ] Roller shoulders
- [ ] Slouching
- [ ] Head tilt

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 of body worker? [ ] YES [ ] NO

SPORTS/ACTIVITIES/HOBBIES:

Sports: _____ Hobbies: _____

Music: [ ] Piano [ ] Violin [ ] Brass [ ] Wind Other: _____

POTENTIAL FOR THERAPY HOME CARE COMPLIANCE:

- [ ] Self started
- [ ] Capable of following directions
- [ ] Will need parent/care taker assistance
- [ ] Home care will be limited

Comments: _____

SLEEP DISTURBANCES – Current or Past:

- [ ] Bedwetting
- [ ] Sleep talking
- [ ] Restless leg syndrome
- [ ] Night terrors/nightmares
- [ ] Tossing/turning
- [ ] Sleep walking
- [ ] Drooling
- [ ] Sleeping in strange body positions
- [ ] Must be upright to sleep
- [ ] Grinds teeth

SLEEP QUALITY CONSIDERATIONS:

Do you practice good sleep hygiene? [ ] YES [ ] NO

How many hours of sleep do you get on average? _____

Do you wake up feeling well rested? [ ] YES [ ] NO Do you feel tired during the day? [ ] YES [ ] NO

Do you experience "brain fog", forgetfulness, feeling "spaced out"? [ ] YES [ ] NO

Difficulty falling back to sleep? ☐ YES ☐ NO

Do you feel chronically fatigued or run down? ☐ YES ☐ NO

Do you experience insomnia? ☐ YES ☐ NO ☐ Medically diagnosed ☐ Self diagnosed

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 at night? ☐ YES ☐ NO ☐ Do you snore? ☐ YES ☐ NO

Have you been told that you snore? ☐ YES ☐ NO

Has a bed partner 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 Results: _____

Do you currently have a CPAP or MAD (Mandibular advancement device)? ☐ YES ☐ NO

How often do you wear it? ☐ Daily ☐ Intermittently