Just Breathe

SARAH FOWLER, RDH

MYOFUNCTIONAL THERAPIST

Child Assessment Form

Please answer the questions below regarding your child to the best of your knowledge. If you answered "yes" to many of the questions, please consider scheduling a comprehensive myofunctional exam so that your child can get the benefit of early myofunctional intervention. Myofunctional impairment and suggested therapies are best understood after a full examination to determine your child's needs and the best therapy approach.

1. ____ Was your child bottle fed?
2. ____ Did your child suffer from latching issues, colic, acid reflux, "spitting up" a lot, feeding troubles, ear infections or "failure to thrive" as an infant?
3. ____ Has your child had his/her tonsils removed or has he/she been told his/her tonsils are enlarged?
4. ____ Do you notice that your child's mouth is open at rest (even occasionally)?
5. ____ Does your child breathe through his/her mouth?
6. ____ Has your child experienced any breathing issues or difficulties? (chronic congestion, asthma, seasonal allergies, etc.)
7. ____ Does your child take medications to help "manage" the breathing problems but never seem to find the root cause?
8. ____ Has your child had (or has it been recommended to have) nasal surgery for: deviated septum or any other condition or other airway surgery?
9. ____ Does your child's tongue rest anywhere other than entirely on the roof of his/her mouth?
10. ____ Has anyone ever told you that your child may have a tongue thrust?
11. ____ Has your child experienced any issues with digestion? (stomach aches, burping, gas, acid reflux, etc.)
12. ____ Do you notice that your child has a hyperactive gag reflex? Texture sensitivity?
13. ____ Does your child find it difficult to breathe and chew food at the same time?
14. ____ Does your child suck his/her thumb/finger/blanket or other object or has he/she had a pacifier for an extended period of time?

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15. ____ Has your child ever had braces and experienced a relapse in treatment?

16. ____ Has your child ever had palatal expansion, teeth extracted to “make room” or headgear?

17. ____ Has anyone ever told you that your child may be tongue-tied?

18. ____ Has your child ever had trouble with speech or been in a speech therapy program?

19. ____ Does your child suffer from chronic headaches, neck and shoulder tension, TMJ pain/tension?

20. ____ Does your child clench and grind his/her teeth?

21. ____ Does your child snore?

22. ____ Does your child wake still feeling tired?

23. ____ Has your child had a sleep study done or been diagnosed with sleep apnea or UARS?

24. ____ Does your child have poor posture?

25. ____ Does your child have difficulty paying attention at home/school?