Rebecca Pokluda, P.C.
KidWorks therapy services

3607 Manchaca Rd., Austin, TX 78704 • 512-444-7219 Phone • 512-444-6005 Fax

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: _____