Momentum Therapy Center

Today's Date: _____

Orofacial Myofunctional Therapy Intake Form

Welcome to Momentum Therapy Center. The information you provide on this form will help us prepare your upcoming Orofacial Myofunctional Therapy Evaluation. Please print and complete the form to the best of your ability. Mail or fax this form before the evaluation date.

Name: _____ Gender: _____ Age: _____

Birthdate: _____

Email address: _____

Home Address: _____

Phone number: _____

Completed by: _____ Relationship: _____

Medical or Developmental diagnosis: _____

Referring Physician? _____

Reason for referral: _____

_____

_____

When did you first notice the issue(s)?: _____

_____

Complete the following if applicable:

Are you currently employed? ◯ Yes ◯ No

Job Title: _____

Place of Employment: _____

Name of person who referred you: _____

Name of Orthodontist: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Name of General Dentist: _____ Phone: _____

Momentum Therapy Center

Address: _____ City/State: _____ Zip: _____

Medical History:

Current health status (check one): ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Physician's Name: _____ NPI # _____

Address: _____

Phone number: _____ Fax number: _____

Diagnosis(es): _____

Specialists (ex. Neurologist, Nutritionist, Allergist): _____

_____

Medication Profile: Please list all current medications and reason for medication

Current Medication	Reason

Please indicate if patient has had any of the following. Include age and degree of severity:

Illness:	Age/Severity:	Illness:	Age/Severity:
Adenoidectomy		Meningitis	
Allergies		Mumps	
Asthma		Pleurisy	
Chicken pox		Pneumonia	
Chronic colds		Polio	
Croup		Rheumatic fever	
Convulsions		Rickets	
Diphtheria		Running ears	
Ear aches		Scarlet fever	
Encephalitis		Sinus	
Enlarged glands		Small pox	
Headaches		Tonsillitis	
Head injuries		Tonsillectomy	
Heart problems		Thyroid	

High fever		Tuberculosis	
Influenza		Typhoid	
Mastoidectomy		Venereal disease	
Measles		Whooping cough	

Do you still have your tonsils and adenoids? ◯ Yes ◯ No

Have you received orofacial myofuctional therapy in the past? ◯ Yes ◯ No

If yes, where and by whom? _____

Describe any additional physical or medical problems that may have an effect on therapy?

_____

_____

_____

Recent hospitalizations? ◯ Yes ◯ No

If yes, please describe: _____

Recent surgeries? ◯ Yes ◯ No

If yes, please describe: _____

Do you have any nervous diseases? ◯ Yes ◯ No

If yes, please describe: _____

Do you suffer from epileptic seizures? ◯ Yes ◯ No

If yes, please describe: _____

Do you have a tendency to be tense and/or nervous? ◯ Yes ◯ No

If yes, please describe: _____

Have you had any type of counseling or psychotherapy? ◯ Yes ◯ No

If yes, please describe: _____

Do you have any allergies? ◯ Yes ◯ No

If yes, please describe: _____

Do you have difficulty swallowing pills? ◯ Yes ◯ No

If yes, please describe: _____

Are you a mouth breather? ◯ Yes ◯ No

If yes, please describe: _____

Have you every worn any type of orthodontic appliance? ◯ Yes ◯ No

If yes, please describe (include type and for how long): _____

_____

Present Eating and Oral Habits:

Are you a fast eater? _____ Or a slow eater? _____

Do you drink much liquid with your meals? _____

Do you chew your food with your mouth open? _____

Do you gulp your food or liquids? _____

Are you a noisy eater? _____

Please check all oral or sucking habits that apply to you/patient:

◯ Thumb sucking ◯ Fingernail biting

◯ Finger sucking ◯ Lip biting

◯ Tongue sucking ◯ Lip licking

◯ Sucking on pacifier

Primary reason for seeking therapy? _____

_____

_____

_____

What is your vision or goal for therapy? _____

_____

_____

_____

_____