Southwest myofunctional therapy

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Patient Intake

First Name:_____ Middle Initial:_____ Last Name:_____ Suffix:_____
Date of Birth:_____/_____/_____ Gender:_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed
Street Address:_____ City:_____ State:_____ Zip Code: _____
Preferred Phone Number:_____ Email:_____
Whom shall we contact in a medical emergency?_____ Phone Number:_____
Whom may we thank for referring you to us? _____

Describe the problem about which you are most concerned about? _____
_____

How long have you had this problem?_____
_____

Does anything make it better or worse?_____
_____

Is this problem currently giving you pain? ☐ Yes ☐ No If yes, where and how much pain?_____
_____

What result would you like to achieve through treatment here at Southwest Myofunctional Therapy? _____
_____

Current Primary Physician:_____Phone Number:_____
Any Other Medical Specialists?_____
Current Dentist:_____ Phone Number:_____
Do you currently see a sleep specialist? ☐ Yes ☐ No If yes, who? _____

Do you take any medications, including over-the-counter and supplements? ☐ Yes ☐ No If yes, please list the name and dosage below.

Medication Name	Dose	Medication Name	Dose

Have you ever had an allergic reaction to any medications and or substances? ☐ Yes ☐ No If yes, please list them below.

Medication / Substance	Description of Reaction

Do you suffer from any seasonal allergies? ☐ Yes ☐ No
If yes, please list them. _____
_____

Do you currently have or have had a history of any pain, medical disorders or diseases? ☐ Yes ☐ No If yes, please mark the box next to it below. ***It is especially important to know if you had any of these as a child.***

☐ Pain in the teeth or gums	☐ Frequent headaches or migraines.	☐ High / Low blood pressure.
☐ Pain in the joints of jaw.	☐ Neck pain.	☐ Anemia
☐ Trouble chewing.	☐ Numbness in arms or hands.	☐ Asthma
☐ Trouble speaking.	☐ Paralysis / loss of sensation.	☐ Emphysema
☐ Trouble swallowing.	☐ Snoring	☐ COPD / Shortness of breath.
☐ Clicking / Grinding of jaw joints.	☐ Daytime sleepiness.	☐ Chest pain.
☐ Pain when opening and closing jaw.	☐ Frequent awakening.	☐ Arthritis
☐ Difficulty opening and closing jaw.	☐ Tooth grinding while sleeping.	☐ Hepatitis
☐ Pain inside of the ear.	☐ Obstructive sleep apnea.	☐ HIV / AIDS
☐ Clogged or Stuffy ears.	☐ Restless leg syndrome.	☐ Tuberculosis
☐ Difficulty hearing.	☐ Nasal congestion.	☐ Mononucleosis
☐ Ringing in ears.	☐ Nasal drainage.	☐ Bronchitis
☐ Ear infections.	☐ Strep infections.	
	☐ Sinus infections.	
	☐ Gastric reflux.	

Any history of speech therapy? ☐ Yes ☐ No
Any history of attending occupational therapies? ☐ Yes ☐ No ☐ Used to
Any history of physical therapy sessions? ☐ Yes ☐ No ☐ Used to
Do you suffer from any sleeping disorders or use any devices to assist you in sleeping? ☐ Yes ☐ No If yes, please answer the following questions.
Have you tried using a dental device for OSA or snoring? ☐ Yes ☐ No If yes, which?_____
Have you tried using a Continuous Positive Air Pressure (C-PAP) device? ☐ Yes ☐ No If no, please indicate why below.
_____
Are you currently pregnant? ☐ Yes ☐ No If yes, when is the due date? _____
Have you gone through menopause? ☐ Yes ☐ No
Are you currently having any dental work done as of this moment? ☐ Yes ☐ No
Have you ever worn a dental splint? ☐ Yes ☐ No
Do you currently smoke? ☐ Yes ☐ No ☐ Used to
If yes please indicate the following: _____ Number of packs a day. _____ Years smoking.
Do you drink alcohol? ☐ Yes ☐ No
Any other substances that may impact your health in a significant manner (ie. illegal, harmful substances). _____
Have you had any major surgeries within the past 10 years? ☐ Yes ☐ No If yes, please list out **all** major surgeries.
_____
_____

Patient Name (Printed):

_____

Patient Signature:

_____

Date of appointment:

_____