Southwest myofunctional therapy

Sandraluz Gonzalez *RDH, COM®, BBE*
(505) 850-4902
swmyofunctional.com

Adolescent Patient Intake

First Name:_____ Middle Initial:_____ Last Name:_____ Suffix:_____
Date of Birth:_____/_____/_____ Gender:_____
Street Address:_____ City:_____ State:_____ Zip Code: _____
Preferred Phone Number:_____ Email:_____
Parent / Guardian 1 First Name:_____ Last Name:_____
Relationship to minor:_____ Phone Number:_____ Email:_____
Parent / Guardian 2 First Name:_____ Last Name:_____
Relationship to minor:_____ Phone Number:_____ Email:_____

Whom may we thank for referring you to us? _____
Please list the reason for visiting our practice?

- ☐ Snoring / Sleep Issues
- ☐ Mouth breathing / Nasal blockage
- ☐ Voice Problems
- ☐ Referred by a dental / medical professional
- ☐ Frenulum evaluation
- ☐ Tonsil and adenoid evaluation
- ☐ Autism / ADHD
- ☐ Other reasons (please list): _____

Has your child ever had surgery? ☐ Yes ☐ No
If so, please provide us with details. _____

Current Primary Physician:_____Phone Number:_____
Any Other Specialists?_____
Current Dentist:_____ Phone Number:_____
Do you currently see a sleep specialist? ☐ Yes ☐ No If yes, who? _____
Would you like us to inform either provider about your treatment ☐ Yes ☐ No
Does your child 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

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

Medication / Substance	Description of Reaction

Does your child suffer from any seasonal allergies? ☐ Yes ☐ No
If yes, please list them. _____

Does your child currently have or have had a history of pain, medical disorders or diseases? ☐ Yes ☐ No If yes, please mark the box next to it below.

- ☐ Pain in the teeth or gums
- ☐ Pain in the joints of the jaw.
- ☐ Trouble chewing.
- ☐ Trouble speaking.
- ☐ Trouble swallowing.
- ☐ Difficulty opening and closing jaw.
- ☐ Nasal congestion.
- ☐ Nasal drainage.
- ☐ Strep infections.
- ☐ Sinus infections.
- ☐ Pain inside of the ear.
- ☐ Clogged or Stuffy ears.
- ☐ Ringing in ears.
- ☐ Ear infections.
- ☐ Difficulty hearing.
- ☐ Snoring
- ☐ Daytime sleepiness.
- ☐ Tooth grinding while sleeping.
- ☐ Obstructive sleep apnea.
- ☐ Restless leg syndrome.
- ☐ Noisy breathing at night
- ☐ Asthma
- ☐ Neck pain.
- ☐ Chest pain.
- ☐ Frequent headaches or migraines.
- ☐ Difficulty concentrating
- ☐ Open mouth breathing
- ☐ Difficulty breathing through the nose
- ☐ 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

_____ _____

Parent / Guardian Signature **Parent / Guardian Name (Print)**

_____ _____

Patient Signature **Patient Name (Print)**

_____

Date of appointment