**Patient History & Assessment**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Exam: \_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_

Parent/Sibling Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent email (for zoom):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex allergy?: Yes No

Patient’s Main Concern/Reason For Seeking Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Breathing History:**

 Allergies? *Yes (Seasonal, Dust, Pets/dander, Other) No*

 Has the patient been formally tested for allergies? *Yes No*

 What medications do they take for their allergies?

What else do they use to relieve symptoms? (saline nasal spray, Neti pot or rinsing, acupuncture, etc.)

Do they have nasal congestion that is not necessarily related to allergies? *Yes No*

 Do they have a history of asthma or currently have asthma? *Yes No*

 Do they take medication? *Yes No*

 Notes/Other:

History of:

*Septoplasty/rhinoplasty Turbinate reduction Nasal polyps*

*Nostril collapse (fast inhale) Empty Nose Syndrome*

*Sinus infections/pressure/headaches/pain Chin implant*

Notes/Other :

Has the patient seen an ENT for an evaluation? *Yes No*

 Has it been recommended to remove the tonsils and/or adenoids? *Yes No*

 Allergic shiners/venous pooling? *Yes No*

 Deviated septum? *Yes No*

 Crease on bridge of nose? *Yes No*

**Early Childhood:**

 Feeding: *Bottle Fed Breast fed Combo Not sure*

 *Difficulty feeding/latching*

 Birth: *Premature Long/difficult labor C-section*

 Other: *Tongue-tied or lip tied as an infant Reflux as infant*

Messy/picky eater? Yes No

 Oral aversions? Yes No

 Open mouth chewing? Yes No

 How quickly do you eat? Fast Moderate Slow

Have you ever noticed?
*Air swallowing Tongue thrust with swallowing Difficulty swallowing pills (if over age 12) Saliva pooling (daytime) Drool on pillow History of choking Frequent food or water “going down the wrong pipe” (aspiration) Difficulty coordinating chewing and breathing Hyperactive gag reflex*

 Notes/Other:

**Oral Habits:**

Current oral habits: *Yes No*

Oral habits in past: *Yes No*

*Thumb Sucking Finger Sucking Nail Biting Prolonged Pacifier Use Sucking on clothing/hair/blanket/etc*

 Notes/Other:

Do you mouth breathe while awake? *Rarely/never Sometimes Often Almost always*

 Do you mouth breathe while asleep? *Rarely/never Sometimes Often Almost always*

**Digestion:**

*Abdominal bloating/cramping Burping Flatulence*

*Acid reflux/Heartburn/GERD Laryngopharyngeal Reflux (LPR)*

*Irritable Bowel Syndrome (IBS) Leaky gut*

*Small Intestinal Bacterial Overgrowth (SIBO)*

What is the frequency of these symptoms? (Daily, weekly, 3x/month, etc.)

Notes/Other:

**Ears:**

 History of ear problems/infections? *Yes No*

 Current ear problems/infections? *Yes No*

 Tubes placed? *Yes No*

 How many rounds of antibiotics?

 *Tinnitus Vertigo Other symptoms*

 Notes/Other:

**Speech:**

 Has the patient been evaluated by a Speech Language Pathologist? *Yes No*

 If they were treated, what was the focus of speech therapy?

Does the patient or parent believe that there are current speech concerns? *Yes No*

 If so, what are they?

 *“S” sound/lisp “R” or “L” problems General lack of clarity/mumbling Voice projection*

 Notes/Other:

**Head, Neck, and Jaw:**

 Pain or tension: *Neck Shoulders Migraines Headaches TMJ Facial*

 Frequency:

 Pain level (1-10):

 Grinding: Yes No

 Night guard/splint use or recommendation: Yes No

**Posture and Bodywork:**

 *Forward head posture Rolled shoulders Slouching*

Has the patient ever worked with a professional on posture? (PT, OT, Yoga, Personal trainer): *Yes No*

Has the patient ever seen a chiropractor, PT, massage therapist, cranial osteopath, or any other type of body worker? *Yes No*

 Other/Notes:

**Sleep Disordered Breathing:**

 How many hours of sleep do you get on average?

 Do you wake up feeling well rested? *Yes No*

 Do you feel tired during the daytime? *Yes No*

 Do you experience brain fog, forgetfulness, feeling “spaced out”? *Yes No*

 Do you feel chronically fatigued or run down? *Yes No*

 Do you experience insomnia? *Yes No*

 Do you mouth breathe or heavy breathe at night? *Yes No*

 How would you describe your sleep?

 *Interrupted Restless Light sleeper Deep sleeper Soaked in sweat Wake up to use restroom regularly*

 Have you experienced or been diagnosed with any of the following conditions?

 *Snoring Upper Airway Resistance Syndrome (UARS)*

*Obstructive sleep apnea Central sleep apnea*

 Has a bed partner ever heard you stop breathing at night? *Yes No*

 Has a dentist or doctor ever recommended a sleep study? *Yes No*

 Have you ever had a sleep study? *Yes No*

 If yes, what was your AHI, RDI, ODI?

 Do you currently have a CPAP or MAD? *Yes No*

 If yes, how often do you wear it?