PATIENT INTAKE FORM AND CONSENT

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____
Street City State Zip

CELL PHONE: _____ REFERRED BY: _____

NAME OF PARENT OR GUARDIAN IF PATIENT IS A MINOR: _____

MEDICAL HISTORY & RESPIRATION: Check what pertains to you most of the time.

1. When awake, lips are ☐ together ☐ apart
2. When asleep, lips are ☐ together ☐ apart
3. Is snoring or audible breathing present when asleep? ☐ yes ☐ no
4. Do you have difficulty getting air through your nose? ☐ yes ☐ no
5. Do you have difficulty putting lips together? ☐ yes ☐ no
6. Do you frequently have a sore throat? ☐ yes ☐ no
7. Do you have respiratory allergies? ☐ yes ☐ no If yes, what medication? _____
8. Do you have asthma? ☐ yes ☐ no If yes, what medication? _____
9. Do you blow your nose often? ☐ yes ☐ no
10. Do you have a history of ear infections? ☐ yes ☐ no
11. Do you have a history of frequent tonsillitis? ☐ yes ☐ no If yes, how frequent? _____
12. Have your tonsils been removed? ☐ yes ☐ no If yes, when? _____
13. Have your adenoids been removed? ☐ yes ☐ no If yes, when? _____
14. Have you been diagnosed with sleep apnea? ☐ yes ☐ no
15. Have you had any other serious injury, surgery, and/or medical diagnosis? If yes, please explain. _____

Comments: _____

TEETH

1. Are you presently wearing braces? ☐ yes ☐ no
   a) If yes, for how long and when will you get them off? _____
   Has your orthodontist ever expressed difficulty in getting your teeth to move or stay properly? ☐ yes ☐ no
   Briefly describe your teeth before you got your braces: _____
   b) If no, have you worn braces before? ☐ yes ☐ no If yes, when? _____
2. Are you presently wearing, or have you worn, any of the following? (When?)
   Palatal Expander: _____ Thumb Reminder Device: _____
   Retainers: _____ Elastics: _____ Other: _____

Comments: _____

ORAL HABITS:

1. I currently suck my ☐thumb ☐fingers or ☐use a pacifier. Would you like to stop? ☐ yes ☐ no
2. I used to suck my ☐thumb ☐fingers or ☐use a pacifier. When did you stop? _____
3. Do you currently bite your fingernails? ☐ yes ☐ no
4. Do you chew/suck on objects, such as ☐straws ☐pencils ☐clothing ☐toys ☐jewelry ☐hair ☐other? _____

Comments: _____

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Laguna Niguel, California 92677
(949) 365-5858

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EATING AND DRINKING: Check what pertains to you most of the time.

1. Do you take ☐ big bites ☐ small bites or ☐ average bites of food?
2. Do you eat ☐ quickly ☐ slowly or ☐ at an average pace?
3. When chewing, your mouth is ☐ open or ☐ closed?
4. Do you have difficulty swallowing dry foods without liquid? ☐ yes ☐ no
5. Do you need to drink after each bite to get the food down? ☐ yes ☐ no
6. Do you have difficulty swallowing pills? ☐ yes ☐ no
7. Do you have excessive indigestion after you eat? ☐ yes ☐ no
8. Have you been diagnosed with a tongue-tie or lip-tie? ☐ yes ☐ no

This question is for your mom:

9. Did your son/daughter ever have difficulty nursing, taking a bottle, or eating as an infant? ☐ yes ☐ no

Comments: _____

JAW OR FACIAL PAIN:

1. Have you ever experienced any of the following? Please check all that apply.

☐ Clicking or popping of the jaw while opening the mouth	☐ Frequent headaches
☐ Grating sound in the jaw joint	☐ Dizziness
☐ Pain while opening the jaw	☐ Ringing or rushing ear sounds
☐ Jaw muscles painful to touch	☐ Hearing change
☐ Jaw locking	☐ Restricted jaw opening
☐ Pain or discomfort in jaw while chewing or swallowing	☐ Tired jaw muscles
☐ Jaw juts forward, backward, or to the side	☐ Grinding teeth during sleep
☐ Clenching teeth together when not talking or eating	

2. What do you think is the cause of your pain or discomfort? _____
3. What aggravates your pain or discomfort? _____
4. What makes it feel better? _____

Comments: _____

SPEECH:

1. Do you currently or have you previously had difficulty saying any sounds? ☐ yes ☐ no
   a) If yes, did you have speech or myofunctional therapy? ☐ yes ☐ no
   b) Was it effective? ☐ yes ☐ no
   c) How long did you have speech and/or myofunctional therapy? _____

Comments: _____

CONSENT:

☐ I give consent for Melissa Beck, a certified Speech-Language Pathologist, to conduct a swallowing and/or speech evaluation which may include an orofacial exam and other swallow or speech related tests that she deems necessary to make a clinical diagnosis.

☐ I understand that payment of the assessment fee of $275.00 is due and payable at time of the evaluation.

☐ I give consent for Melissa Beck, MA, CCC-SLP, OMT to communicate her findings by consultation, phone, e-mail, fax, or postal service with Dr. _____.

_____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN OF MINOR DATE

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AUTHORIZATION AND CONSENT TO USE PHOTOGRAPH OR VIDEO RECORDINGS

PATIENT NAME: _____

I, the undersigned, do hereby consent and agree that OC Orofacial Myology, Inc., and its employees, and/or agents have the right to take photographs, video, or digital recording of me or my dependent and to use these in any and all media, including educational materials, informational and conference presentations, social media, website, before/after photos etc.

(Mark your choice below)

☐ **YES** -- Including full face.

☐ **YES** -- But please exclude any recognizable facial features.

☐ **NO** -- Photographs may only be used for medical record keeping and treatment planning only.

I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

(Mark your choice below)

☐ **YES** -- Use my name.

☐ **NO** -- I prefer to remain anonymous.

By signing this form below, I confirm that this consent form has been explained to me in terms that I understand. I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I understand that there will be no financial or other remuneration for the recording, either for initial or subsequent transmission or playback. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Name of Authorizing Individual: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

If this release is obtained from a patient under the age of 18, then the signature of the parent or legal guardian is required.

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