AEI **Airway** *focused* Lingual *posture* Facial *growth guidance*

EVALUATION

Name: _____ Age: _____ DOB:_____ Date: _____

Chief Complaint(s) : _____

1. Describe pregnancy: _____
2. Describe birth delivery: (c-section, prolonged, epidural, induced, breach, forceps, bruising etc.) _____

   _____
3. Breast fed? how long? YES NO Explain: _____
4. Painful, noisy, problems latching with breast feeding? YES NO

   Explain: _____
5. History of frenectomy or diagnosed tongue tie? Explain: _____
6. Visit(s) with lactation consultant? YES NO Explain: _____
7. Did the baby experience any colic? YES NO Explain: _____
8. Any bottle feeding? YES NO Explain: _____
9. At what age were solid foods introduced? _____
10. Crawling at what age, describe crawl? _____
11. Walking at what age, describe? _____
12. Any trouble with fine or gross motor skill development? (tying shoes, coordination, etc.) YES NO

    Explain: _____
13. Any diseases or illnesses? _____
14. Any problems with skin rashes or eczema? _____
15. Vaccinations (normal, delayed schedule, none)? _____
16. Describe any reactions to the vaccinations? _____
17. History of any medications or antibiotics? _____
18. Any sucking habits? (fingers, nails, shirts, blankets, cheeks, pencils, etc.) _____
19. Sensory issues? (photo sensitive, noise, textures, tags, etc.) YES NO Explain: _____

20. Picky eater? YES NO Describe diet: _____

21. Any gagging? (pills, foods, drinks, etc.) _____

22. Describe any digestive problems? _____

23. Any scars, surgeries, falls or car accidents? Explain: _____

_____

24. Describe sleep? (how long, restless, interrupted, difficulty to fall asleep or wake up, etc.)_____

_____

25. History of night terrors? _____

26. Bed wetting issues? _____

27. Sleep posture? (on back, side, stomach, etc.) _____

28. Teeth grinding? YES NO Explain: _____

29. Snoring? YES NO Explain: _____

30. Breath holding? YES NO Explain:_____

31. Headaches? YES NO Explain: _____

32. TMD pain, clicking, ringing of the ears? YES NO Explain: _____

33. History of ear infections or tubes? YES NO Explain: _____

34. History of chronic congestion or sinusitis? YES NO Explain: _____

35. Any problems with tonsils and adenoids?_____

36. History of Asthma and/or inhaler?_____

37. Breathing? (mouth, nasal, congested, difficulty, wheezing, etc.) _____

38. Mouth open at night during sleep? _____

39. Any allergies? YES NO Explain: _____

40. Any pets? YES NO Explain: _____

41. Any behavior or social issues? (Autism Spectrum, ADD, etc.) _____

_____

42. How are peer-peer interactions, describe: _____

43. Any academic or learning issues? _____

44. Speech issues? (lisp, speech therapy, etc.) _____

45. Activities, sports, musical instruments? _____

46. Any history of previous orthodontics? Explain: _____

47. Problems with cavities in the past? _____

CLINICAL ASSESSMENT (DONE BY DENTIST/STAFF)

48. Posture assessment: (forward head posture, slouched, limp, etc.) _____

49. Gummy smile? YES NO

50. Lip posture (lip seal, sucked in lower lip, etc)?

51. Palate size and shape? _____

52. Diastema's present? YES NO Where: _____

53. Maxillary bone restriction? _____

54. Tongue position? (low tongue posture, anterior thrusts, lateral thrusts, etc.) _____

55. Maxillary frenum: NORMAL MILD MODERATE HEAVY

56. Lingual frenum: NORMAL MILD MODERATE HEAVY

57. Crowding of maxillary or mandibular teeth? _____

58. Open bite? YES NO

59. Crossbites? YES NO Explain: _____

Attitude: Patient :_____ Parent: _____

Patient Goals: _____

myobrace

IMPROVING THE DENTAL & FACIAL DEVELOPMENT OF GROWING CHILDREN

PATIENT INFORMATION

Name: _____ D.O.B: ____/____/_____ Age: _____

_____ D.O.B. _____/___/_____

Parent/Guardian Name (if under 18)

_____

Street City State Zip code

_____

Home Phone Cell Phone Work Phone

Insurance Information:

Subscriber Name_____ DOB__/__/_____ ID#_____

Employer _____ Ins Carrier_____

What is the reason(s) for visiting our Myobrace Clinic?

□ Crooked or crowded teeth □ Incorrect jaw development
□ I/My child doesn't want extractions □ Seeking a second opinion
□ Referred by a dental/medical professional: _____
□ Other reasons (please list): _____

Does the patient have any of the following health problems?

□ Allergies or Asthma □ Headaches, neck or ear pain □ Speech problems
□ Regular ENT infections □ Chronic Mouth Breathing
□ Other (see next page):

How did you hear about Myobrace?

□ Friend/Family □ Magazine/Kid's Directory □ Dentist

Name of Referrer: _____

What is the best way to confirm your appointments:

▫ phone calls ▫ text messages ▫ e-mail

_____ _____ _____

HAS THE CHILD EVER HAD (OR CURRENTLY HAVE) ANY OF THE FOLLOWING MEDICAL CONDITIONS?

□ Yes □ No ADD/ADHD
□ Yes □ No Anemia
□ Yes □ No Arthritis
□ Yes □ No Artificial Joints/Valves
□ Yes □ No Aspergers Syndrome
□ Yes □ No Asthma
□ Yes □ No Autism
□ Yes □ No Behavioral Problems
□ Yes □ No Cancer/Leukemia
□ Yes □ No Cardiac Pacemaker
□ Yes □ No Celiac Disease/Gluten Sensitivity
□ Yes □ No Chicken Pox
□ Yes □ No Cleft Palate/Lip
□ Yes □ No Congenital Heart Defect
□ Yes □ No Craniofacial Anomalies
□ Yes □ No Diabetes
□ Yes □ No Down's Syndrome
□ Yes □ No Epilepsy
□ Yes □ No Glaucoma
□ Yes □ No Handicaps/Disabilities
□ Yes □ No Hearing Impairment
□ Yes □ No Heart Murmur
□ Yes □ No Hemophilia
□ Yes □ No Hepatitis Type:_____
□ Yes □ No HIV/AIDS
□ Yes □ No Hospital Stays _____
□ Yes □ No Kidney/Liver Problems
□ Yes □ No Low Blood Pressure
□ Yes □ No Measles
□ Yes □ No Mental Disorder
□ Yes □ No Mitral Valve Prolapse
□ Yes □ No Nervous Disorder
□ Yes □ No Oppositional Defiance Disorder
□ Yes □ No Pregnancy
□ Yes □ No Pervasive Development Disorder
□ Yes □ No Premed Needed
□ Yes □ No Seasonal Allergies
□ Yes □ No Seizures
□ Yes □ No Sickle Cell Disease
□ Yes □ No Skin Rash _____
□ Yes □ No Speech Impairment
□ Yes □ No Stroke
□ Yes □ No Surgeries:_____
□ Yes □ No Therapies (i.e: speech, occupational, behavioral, developmental _____
□ Yes □ No Thyroid Problems
□ Yes □ No Tuberculosis
□ Yes □ No Ulcers
□ Yes □ No Any other medical conditions we should be aware of: _____
_____
_____

PLEASE LIST ALL DRUGS THE CHILD IS CURRENTLY TAKING: _____

_____

IS YOUR CHILD ALLERGIC TO OR HAVE THEY HAD ANY REACTIONS TO THE FOLLOWING?

□ Yes □ No Barbiturates
□ Yes □ No Sedatives/General Anesthesia
□ Yes □ No Iodine
□ Yes □ No Aspirin
□ Yes □ No Any metals (nickel, mercury, etc)
□ Yes □ No Sulfa Drugs
□ Yes □ No Latex Rubber
□ Yes □ No Local Anesthetics (Lidocaine, Septocaine)
□ Yes □ No Penicillin or other antibiotics (amoxicillin, clindamycin, erythromycin, cephalexin)
□ Yes □ No Other: _____
□ Yes □ No Demerol
□ Yes □ No Lortab (Hydrocodone)
□ Yes □ No Dairy/Milk/Lactose
□ Yes □ No Codeine
□ Yes □ No Vistaril
□ Yes □ No Gluten
□ Yes □ No Nuts

DOES/DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

□ Yes □ No Lip Sucking
□ Yes □ No Nail Biting
□ Yes □ No Mouth Breathing
□ Yes □ No Pacifier Habit
□ Yes □ No Nursing Bottle Habits
□ Yes □ No Thumb/Finger Sucking
□ Yes □ No Clenching/Grinding Teeth

Has the child ever had a serious/difficult problem associated with previous dental work? □ Yes □ No
Is the child's water fluoridated? □ Yes □ No
Is the child taking fluoridated supplements? □ Yes □ No
Has the child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? □ Yes □ No
Does the child experience frequent headaches? □ Yes □ No
Does the child brush his/her teeth daily? □ Yes □ No
Floss his/her teeth daily? □ Yes □ No
Are the child's immunizations current? □ Yes □ No If no, please explain:_____
Anything you would like to discuss with the Doctor in private? □Yes □ No

APT Solutions

Airway Promoted Therapy

Sleep Questionnaire

Check "yes" or "no" for each question

Feeling sleepy often during the day:

☐Yes ☐No

Require naps or nodding off occasionally from being sleepy:

☐Yes ☐No

Overweight, especially if difficult to control:

☐Yes ☐No

Severe overweight or large neck size: (neck circumference over 17 inches in males and over 16 inches in females)
☐Yes ☐No

High blood pressure or diabetes that is difficult to control or on multiple medications:

☐Yes ☐No

Forgetfulness, confusion or frequent accidents:

☐Yes ☐No

Loud snoring, louder than normal conversation:

☐Yes ☐No

Occasional breathing pauses at night:

☐Yes ☐No

Irregular night breathing, followed by a gasp or snort:

☐Yes ☐No

Awakening frequently at night with heartburn, night sweats or erectile dysfunction in men:

☐Yes ☐No

Morning headaches, even occasionally:

☐Yes ☐No

Awakening in the morning still feeling tired, groggy:

☐Yes ☐No

Family history of loud snoring or sleep apnea:

☐Yes ☐No

Irritability or mood change:

☐Yes ☐No