Client Questionnaire
Myofunctional Examination

Please complete the following questions as thoroughly as possible.

Client Name: _____ Date:_____Birthdate: _____Age:_____
Parent(s) Name: _____Referral Source: _____
Orthodontist: _____ General Dentist: _____

1. EARLY FEEDING/ MEDICAL HISTORY:

A. ☐ Breastfeeding was used until the child was: _____
B. ☐ Bottle feeding was used until the child was: _____
C. ☐ There were early feeding problems including:
nursing difficulties; explain: _____
colic _____ special formula _____ difficulty switching to table food
other; explain: _____
D. ☐ Used a pacifier until age:_____
E. ☐ Used a sippy cup until age:_____

2A. ORAL HABITS

A. ☐ I presently suck my thumb or fingers;
_____ I want to stop _____ I don't really want to stop
B. ☐ I have sucked my thumb or fingers in the past; Here's how I stopped:
_____
C. ☐ I presently suck/ chew on_____
D. ☐ I presently bite my nails
E. ☐ I presently lick my lips
F. ☐ I chew gum every day

2B. JAW OR FACIAL PAIN: Have you ever experienced any of the following?

A. ☐ clicking or popping in the jaw, while opening the jaw
B. ☐ grating sound in jaw joint
C. ☐ pain while opening jaw
D. ☐ restricted jaw opening
E. ☐ jaw locking
F. ☐ jaw muscles painful to touch
G. ☐ pain in jaw while chewing
H. ☐ tired jaw muscles
I. ☐ dizziness
J. ☐ hearing change
K. ☐ ringing or rushing ear sounds
L. ☐ frequent neck aches
M. ☐ discomfort during chewing/swallowing
N. ☐ bruxing (grinding) teeth during sleep

O. ☐ clenching teeth together when not talking or eating
P. ☐ jaw juts forward or back, and locks in place when at rest/ talking/ eating

* What do you think is the cause of your pain? _____
_____
* What aggravates your pain?_____
_____
* What makes it feel better? _____
_____

3. POSTURE & RESPIRATION: Check what pertains to you most of the time

A.	☐ have poor posture	**or**	☐	have good posture
B.	☐ lips are apart when awake	**or**	☐	lips are together when awake
C.	☐ lips are apart when asleep	**or**	☐	lips are together when asleep
D.	☐ open mouth breathing feels best	**or**	☐	nose breathing feels best
E.	☐ difficulty putting lips together			
F.	☐ difficulty getting air through your nose			
G.	☐ have chapped lips frequently			
H.	☐ have frequent colds			
I.	☐ have allergies; if yes, what medication? _____			
J.	☐ have sinus problems; if yes, what medication?_____			
K.	☐ have asthma; if yes, what medication? _____			
L.	☐ blow nose a lot	**or**	☐	don't blow nose very often

4. SPEECH

A. ☐ No, I do not have a speech problem
B. ☐ I have had a speech problem in the past; explain: _____
C. ☐ Yes, I currently have a speech problem; explain: _____
☐ I have had speech therapy; explain: _____
☐ I have not had speech therapy; explain: _____

5. SENSITIVITY- Gag Reflex

A. Do you ever gag while brushing your teeth? ◯ No ◯ Yes
B. Do you ever gag while chewing/ swallowing? ◯ No ◯ Yes

6. PALATE

A. Are you presently using a palate widening device? ◯ No ◯ Yes
If yes, for how long? _____ When will you get it off?_____
B. Did you have a palate widening device in the past? ◯ No ◯ Yes
If yes, when? _____ How long did you wear it?_____
Describe your palate before you got your device:_____

7. TEETH

A. Are you presently wearing braces? ◯ No ◯ Yes
If **yes**, for how long?_____ When will you get them off?_____
If **yes**, has your orthodontist ever expressed difficulty in getting your teeth to move or stay properly? ◯ No ◯ Yes; Explain_____
If **no**, have you worn braces before? ◯ No ◯ Yes When?_____
If **no**, are you going to be getting braces? ◯ No ◯ Yes When?_____

B. Are you presently wearing, or have worn, any of the following: (please write in dates)
_____head gear _____elastics _____retainers _____positioner
_____ palate widening device _____gate or fence _____thumb or reminder appliance
_____ other:_____
C. Briefly describe your teeth before you got your braces:_____
_____

8. TONGUE & THROAT

A. Do you have difficulty lifting your tongue to your palate with your mouth wide open?
_____No_____Yes: Explain:_____
B. When your tongue is resting, where does it sit?_____
C. Have you had a lingual (tongue) frenectomy? ___ No ___ Yes; When?_____
D. Have you had a labial (lip) frenectomy? ___ No ___ Yes: When?_____
E. Have you had frequent tonsillitis? ___ No ___ Yes; Last Episode?_____
F. Have you had your tonsils removed? ___ No ___ Yes; When?_____
G. Have you had your adenoids removed? ___ No ___ Yes; When?_____
H. Have you had ear infections? ___ No ___ Yes
How were they treated_____

9. SWALLOWING

When you swallow, does your tongue make contact with your teeth? ___ No ___ Yes
If yes, which teeth does your tongue touch?_____

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

A. ☐ take *big* bites of food **or** ☐ take small bites of food **or** ☐ take *average* bites
B. ☐ eat *quickly* **or** ☐ eat *slowly* **or** ☐ eat *average* pace
C. ☐ chew with mouth *open* **or** ☐ chew with mouth *closed*
D. ☐ drink more than one beverage with meals? How many on average?_____
E. ☐ have difficulty swallowing dry foods without liquid
F. ☐ need to drink after each bite, to get the food down
G. ☐ have difficulty swallowing pills, now, or in the past
H. ☐ have excessive indigestion during/ after meals ☐ burping ☐ gas ☐ constipation

11. DIET: Describe your typical diet:

Breakfast: _____ Liquids: _____
AM Snack: _____ Liquids: _____
Lunch: _____ Liquids: _____
PM Snack: _____ Liquids: _____
Dinner: _____ Liquids: _____
Evening Snack: _____ Liquids: _____
How many sodas do you drink per week? _____
How many candies do you eat per week? _____
Are you a finicky eater? _____
How many vegetables do you eat per week? _____
How many fruits do you eat per week? _____
How many sweets do you eat per week? _____

12. INJURY HISTORY: Describe any head or neck injuries you have had:

A. _____

_____

At what age did it occur?_____

How did it occur?_____

_____

What were the immediate effects? _____

_____

Were there any lasting effects? _____

B. _____

_____

At what age did it occur?_____

How did it occur?_____

_____

What were the immediate effects? _____

_____

Were there any lasting effects? _____

13. ACTIVITIES

Check the one that applies to you:

___☐___ Active ___☐___ Limited Activity ___☐___ Inactive

List your sports _____

List your hobbies _____

List your group activities _____

List your family activities _____

Do you play any MUSICAL INSTRUMENTS? _____◯_____No _____◯_____Yes

Which one? _____

14. I understand that before, during and after pictures will be taken of my face, mouth and jaw documenting my progress.

Please note that successful completion of the Myofunctional Therapy program is dependent upon patient desire, good attitude and self discipline. When treating children, parental involvement and encouragement are important and necessary as well. Only with a dedicated family and a cooperative patient can we guarantee effective swallowing and resting posture results.

Please sign below to show that you understand the level of commitment involved.

_____ _____

Parent's Signature (If applicable) Date

_____ _____

Client's Signature Date