Goshen Speech & Hearing Center

(845) 360-9323

2002 Route 17M Goshen, NY 10924

Oral Myology Case History

Name: _____

DOB: _____

Referring Physician: _____

Date of Evaluation: _____

Primary Language: _____

Secondary Language (if applicable)_____

Birth History:

Were there any complications during pregnancy? ___yes ___no

If yes, please expand: _____

Was your child delivered full term? ___yes ___no

If not, at how many weeks of gestation? _____

Were there any complications upon delivery? ___yes ___no

If yes, please expand: _____

Did your child require any special care after delivery? ___yes ___no

If yes, please expand: _____

Medical History:

Does your child have a medical or educational diagnosis? ___yes ___no

If yes, please expand: _____

Does your child experience any of the following? (check all that apply)

___Frequent Colds ___Bronchitis ___Strep/Sore Throats ___Asthma

___Recurrent ear infections ___Seasonal Allergies ___Chronic Congestion

___Food Allergies (Please list: _____)

___Cardiac issues ___Hearing issues ___Constipation ___Diarrhea

___Reflux/GERN ___Frequent spit up ___Snoring ___Failture to thrive

___Restless sleeper ___Sleep apnea ___Bed wedding

Has your child ever been hospitalized? ___yes ___no

If yes, please elaborate: _____

Has your child been on medication? ___yes ___no

If yes, please list: _____

Is your child currently on medication? ___yes ___no

If yes, please list: _____

Has your child received any related services? (i.e. Occupational therapy, physical therapy, speech

therapy): _____

Dental History:

Has your child been seen by a dentist? ___yes ___no

Does the dentist have any concerns about structure? ___yes ___no

Has your child experienced any of the following? (check all that apply):

__cavities ___tooth extractions ___periodontal disease ___trauma to the mouth

Feeding History:

Early feeding methods (check all that apply):

___breastfeeding ___attempted breast feeding

___bottlefed ___NG tube

Comments: _____

Difficulties with early feeding (check all that apply):

___Excessive Burping ___Projectile Vomiting ___Excessive spit up

___GERD ___Fatigued Easily ___Lip/Tongue Tie

___Choking ___Gagging ___Excessive Drooling

Comments:_____

Did your child use a pacifier? ___yes ___no

If yes, for how long? _____

At what age did you introduce solid foods? _____

Did your child have difficulty transitioning to a straw cup? ___yes ___no

If yes, please elaborate: _____

Did your child have difficulty transitioning to an open cup? ___yes ___no

If yes, please elaborate: _____

What type of a cup does your child utilize at this time? _____

Does your child have any difficulty managing the following food textures? (check all that apply):

___smooth pureed foods ___chunky pureed foods ___dissolvable solids (i.e. cheerios)

___soft fruits/vegetables ___chicken/meat ___crunchy snacks

Is your child on a special or restricted diet (i.e. gluten free, dairy free)? ___yes ___no

If yes, please elaborate: _____

Does your child have any food aversions? ___yes ___no

If yes, please elaborate:_____

Oral Habits:

Does your child present with any of the following oral habits? (check all that apply)

___excessive drooling ___extended pacifier use ___extended bottle use

___thumb sucking ___mouthing of hands ___mouthing of objects (i.e. toys)

___mouthing of clothing ___biting nails ___mouth breathing

Speech History:

Does your child have a history of speech, language or hearing difficulties? ___yes ___no

If yes, please expand: _____

What percentage of your child's speech do you understand? _____%

What percentage of your child's speech do other's understand? _____%

Additional comments and/or concerns:

_____

_____

_____

_____

_____

_____

_____