Adult/Child Tongue and Lip Tie Questionnaire

Patient Name_______________________________________ DOB__________________ Date__________________

Medical issues ____

Allergies ____________________________________ Previous tongue/lip surgeries ____________________________

Has an Intra- Oral Photo been taken? Y/N _______________*(please initial)*

Has patient experienced any of the following issues? Please check all that apply.

_________ Speech (difficult to understand, lisp, mumbling, baby talk)

_________ Eating (frustration swallowing, packs food in cheeks, gagging, picky eater)

_________ Feeding issues as an infant (difficulty breastfeeding, painful for mother)

_________ Sleep issues (grinds teeth, restless sleep, wets bed, snores, mouth-breather)

_________ Dental issues (excessive crowding, gum recession, high caries risk)

_________ Other issues (TMJ pain, reflux, frequent headaches/neck pain, large tonsils, ADHD)

If other, please list ____

Pediatrician/ GP ____

Speech Therapist/ Feeding Therapist ____

****FOR OFFICE USE ONLY****

Recommend myofunctional therapy follow up: Y or N

If yes, reason(s) for Myofunctional Therapy:

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Doctor's signature ____ Date ________________________