CENTER FOR OROFACIAL MYOLOGY

208.793.7006 | 8601 W. Emerald St Suite 150 Boise, ID 83704 | frontdesk@boiseshc.com

Pediatric Intake Forms Current Date:___/___/___

Patient Information:

Legal name:______________________________ Nickname:_________ DOB:__________
Current Age:_____________ Gender: ☐ male ☐ female
Street Address _____________________________ City:__________ State:___ Zip_____
Height: ______________ Weight:___________

Contact Details

Parent/Guardians Name (if under 18):____
Home phone ________________ Work phone____________ Cell phone ___________
Cell phone provider: ________________ email:_________________________________
Primary Care Physician:_____________________ Referring Physician:______________
Preferred pharmacy:________________________
How did you hear about us? ____

Insurance Information:

Primary insurance company:_________________________________ Phone:__________
Subscriber name: ______________________ Relationship: ________________________
Subscriber DOB:_____________ ID#___________________ Group #________________
Secondary insurance company:_______________________________ Phone:__________
Subscriber name: ______________________ Relationship: ________________________
Subscriber DOB:_____________ ID#___________________ Group #________________

Patient Questionnaire:

WHAT IS THE REASON(s) FOR VISITING OUR PRACTICE?

☐ Snoring/Sleep Issues ☐ Frenulum evaluation ☐ Tonsils and adenoid eval
☐ Mouth breathing/ Nasal Blockage ☐ Voice problems
☐ Autism, ADHD, developmental delay
Other: ____

1. How long has your child had this problem?_______________________________
2. How severe is this problem? (Circle) 1 2 3 4 5 6 7 8 9 10
   Mild very severe
3. How often does this problem occur? ☐ constant ☐ comes and goes
4. What makes it better? ____

5. What makes it worse?____
6. What other symptoms are they having?______________________________

PAST MEDICAL HISTORY (Please check all symptoms you have):

☐ High blood pressure	☐ Asthma/Emphysema	☐ Rheumatic Fever
☐ Kidney disease	☐ Stroke/mini-stroke	☐ Sinusitis
☐ Diabetes	☐ Heart disease/Angina	☐ Peptic Ulcers
☐ Neck/Back disease	☐ Hepatitis/Liver disease	☐ Thyroid disease

☐ Cancer (please list type and date diagnosed): ________________________________

Other:____

____

PAST SURGICAL HISTORY (please check all surgeries you have had):

Has your child ever had surgery? ☐ Yes ☐ No

Has your child ever been hospitalized? ☐Yes ☐ No if yes, what for:

____

☐ Heart bypass/valve	☐ Gall bladder	☐ Prostate removal
☐ Coronary angioplasty	☐ Lung surgery	☐ Colon removal
☐ Carotid artery surgery	☐ Joint replacement	☐ Appendix removal
☐ Vascular bypass	☐ Back surgery	☐ Sinus surgery
☐ Mastectomy	☐ Brain surgery	☐ Tonsillectomy
☐ Heart transplant	☐ Liver transplant	☐ Kidney transplant

Other

____

____

MEDICATIONS (List all your current medications and the dose you take):

Medication:____________________________________ Dose: _________________

Medication:____________________________________ Dose: _________________

Medication:____________________________________ Dose: _________________

Medication:____________________________________ Dose:_________________

Do they take Aspirin or Ibuprofen? ☐ Yes ☐ No

Do they take Warfarin (Corumadin)? ☐ Yes ☐ No

ALLERGIES (circle all that apply)

None Dust Pollen Moldy places Cut grass Animals Food

Smoke/Fumes Outside in spring/fall Air Conditioning Outside on Windy Day

Latex Iodine Tape Contrast agents(Dye)

Other allergies/Problems not listed :

____

____

FAMILY HISTORY (check all illnesses that run in your family):

☐ Hearing loss	☐ Alcoholism	☐ Heart Attack
☐ High blood pressure	☐ Psychiatric illness	☐ Cancer
☐ Sickle cell anemia	☐ Bleeding problems	☐ Diabetes
☐ Poor circulation	☐ Anesthesia reaction	☐ Stroke

Others:____

SOCIAL HISTORY:

With whom does your child live?____

Does your child smoke? ☐ Yes ☐ No (☐ cigarettes, ☐ cigar, ☐ pipe)

How much, and for how long have they smoked? _____ packs per day for ___years

Is your child exposed to secondhand smoke? ☐ Yes ☐ No

Does your child drink alcohol? ___________________________________

Does your child use street drugs: ______________________________________

Does your child have a drug addictions? ☐ Yes ☐ No

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past)

CONSTITUTIONAL

☐ weight loss_____________pounds in the past _________weeks ☐ fever/chills

EYES	ENT:		
☐ Double Vision	☐ Hearing loss	☐ Nose Drainage	☐ swallowing pain
☐ Loss of Vision	☐ Ringing in ears	☐ Nasal Congestion	☐ voice change
☐ Eye pain	☐ Dizziness	☐ Facial Pain	☐ snoring
	☐ Ear pain	☐ Headaches	☐ Hoarseness
	☐ Ear drainage	☐ Sore mouth/throat	☐ poor sleep

CARDIOVASCULAR/PULMONARY

☐ Chest pain	☐ Heart attack	☐ irregular heartbeat
☐ Poor circulation	☐ Leg pain during walking	☐ coughing up blood
☐ Shortness of breath	☐ Asthma	

GASTROINTESTINAL

☐ Stomach ulcers	☐ Nausea/vomiting	☐ Diarrhea
☐ Blood in stool	☐ Trouble swallowing	☐ Abdominal pain

GENITOURINARY

☐ Blood in urine ☐ Pain during urination ☐ Difficulty making urine

MUSCULOSKELETAL

☐ Neck/spine surgery ☐ Neck of Back Disorder ☐ Arthritis

NEUROLOGICAL

☐ Stroke	☐ Ministroke	☐ Loss of sensation
☐ Temporary loss of vision or speech control		☐ Facial paralysis
☐ Paralysis of an arm or leg		

SKIN

☐ Skin cancers ☐ allergy to medical tape, iodine, or latex

PSYCHIATRIC

☐ Clinical depression ☐ Schizophrenia ☐ Anxiety

☐ Hallucinations ☐ Other psychiatric disorder (list)______________________

______________________________ ______________________

Attending Signature Date

Pediatric Questionnaire

Please answer Yes/No, or leave blank if unsure. Provide additional information as desired.

1. When sleeping, does your child ever snore? ☐ Yes ☐ No
2. When sleeping, does your child ever appear to stop breathing? ☐ Yes ☐ No
3. When sleeping, does your child ever gasp or wake with a startle? ☐ Yes ☐ No
4. When sleeping, is your child's body ever in odd positions? ☐ Yes ☐ No
5. When sleeping, does your child have their head extended back? ☐ Yes ☐ No
6. When sleeping, does your child grind their teeth? ☐ Yes ☐ No
7. When sleeping, does your child sweat more than usual? ☐ Yes ☐ No
8. When sleeping, does your child breathe with their mouth open? ☐ Yes ☐ No
9. When sleeping, does your child leave drool on the pillow? ☐ Yes ☐ No
10. Does your child have difficulty falling asleep? ☐ Yes ☐ No
11. Does your child have difficulty staying asleep? ☐ Yes ☐ No
12. Does your child wake up and then have trouble going back to sleep? ☐ Yes ☐ No
13. Does your child sleep lightly and are they easily roused? ☐ Yes ☐ No
14. Does your child wake up groggy and/or moody? ☐ Yes ☐ No
15. Does your child wake up with a headache? ☐ Yes ☐ No
16. Does your child appear lethargic or hyperactive during the day? ☐ Yes ☐ No
17. Does your child have nightmares? ☐ Yes ☐ No
18. Does your child sleepwalk or talk? ☐ Yes ☐ No
19. Does your child wet the bed? ☐ Yes ☐ No
20. Does your child toss and turn while asleep? ☐ Yes ☐ No
21. Does your child have problems with anxiety or behavioral issues? ☐ Yes ☐ No
22. Does your child have fidgety legs? ☐ Yes ☐ No
23. Does your child wake up in a tangle of bedclothes or on the wrong side of the bed? ☐ Yes ☐ No
24. Does your child chew with mouth open/messy eater? ☐ Yes ☐ No
25. Does your child exhibit thumb sucking or chewing on foreign objects (pencil, nail, hair, etc.) ☐ Yes ☐ No

26.How many hours of sleep does your child get, on average, in a 24-hour period including naps? (Circle)

Less than 6 6-7 7-8 8-9 9-10 10-11 11-12 13-14 15-17

National Sleep Foundation Recommended Sleep Times

Toddler (1-2 years)	11-14 hours
Preschoolers (3-5 years)	10-13 hours
School Aged children (6-13 years)	9-11 hours
Teenagers (14-17 years)	8-9 hours

I have truthfully answered all of the above questions and agree to inform your practice of any changes in my child's medical history. In addition, I certify that I have custody and do authorize informed consent for the practice to perform a complete medical, dental, and/or myofunctional evaluation of the patient.

PARENT/GUARDIAN NAME:________________________

SIGNATURE______________________ DATE_______

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EVALUATION RESERVATION POLICY

The Center for Orofacial Myology strives to maximize each patient's potential. Careful planning and time goes into preparing for an evaluation. There is a waiting list for current evaluation slots.

Please be advised that when booking your evaluation appointment we will ask for your credit/debit card number and you will be charged a deposit of ***$50 (fifty dollars)*** *to hold your time slot. After you complete your scheduled evaluation and we bill your insurance, this deposit will be used towards your patient balance or any future sessions. If your insurance covers 100% of your evaluation and session charges, the deposit will be refunded to you after we receive your insurance payment.*

If you must reschedule your evaluation appointment, you must do so at least ***48 hours*** *(two days) before your appointment. The fee for less than 48 hours notice is* ***$50 (fifty dollars)***, ***a full forfeiture of your deposit***.

If you cancel your evaluation appointment and choose not to reschedule, ***your credit/debit card will be charged $250 (two hundred fifty dollars).***

If you fail to show up for your scheduled evaluation and have not given us any notice, ***your credit/debit card will be charged $250 (two hundred fifty dollars)***.

I hereby authorize Chatterton Speech Therapy (doing business as Center for Orofacial Myology) to charge my credit/debit card in the amount of $50 to hold my time slot and agree to the terms and conditions explained above.

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Signature *Date*