Child Lip & Tongue Tie Assessment

Patient's Name _____Birthday _____Age_____ Today's Date _____
Pediatrician: _____ Speech Therapist: _____ Referred by: _____
Previous release of tongue? _____Method (laser, scissor, scalpel):_____ Date of release:_____

1. Has your child experienced any of the following issues? Please check or elaborate as needed.

Speech
___ Frustration with communication
___ Difficult to understand by parents
___ Difficult to understand by outsiders
___ % Percent of time you understand your child
___ Difficulty speaking fast
___Difficulty getting words out (groping for words)
___ Trouble with sounds (which?)_____
___ Speech delay (when?)_____
___ Stuttering
___ Speech harder to understand in long sentences
___ Speech therapy (how long)_____
___ Mumbling or speaking softly
___"Baby Talk"

Feeding
___ Frustration when eating
___ Difficulty transitioning to solid foods
___ Slow eater (doesn't finish meals)
___ Small appetite / Trouble gaining weight
___ Grazes on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky eater/ with textures (which?)_____
___ Choking or gagging on food
___ Spits out food
___Won't try new foods
___ Other:

Nursing or Bottle-Feeding Issues as a Baby
___ Painful nursing or shallow latch
___ Poor weight gain
___ Reflux or spitting up
___ Unable to hold pacifier
___ Milk dribbled out of mouth / messy eater
___ Poor Supply
___ Nipple shield required for nursing
___ Clicking or smacking noise when eating
___ Cried a lot / colic as baby
___ Other:

Sleep issues
___ Sleeps in strange positions
___ Sleeps restlessly (moves a lot)
___ Wakes easily or often
___ Wets the bed
___ Wakes up tired and not refreshed
___ Grinds teeth while sleeping
___ Sleeps with mouth open
___ Snores while sleeping (how often) _____
___ Gasps for air or stops breathing (sleep apnea)

Other related issues
___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Mouth open /mouth breathing during the day
___ Tonsils or adenoids removed previously
___ Ear tubes previously / lots of ear infections
___ Reflux (medicated or not)
___ Hyperactivity / Inattention ___ Constipation

Anything else we need to know:_____

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