Hackensack
Meridian *Health*
Mountainside
Medical Center

TONGUE THRUST EVALUATION INTAKE FORM

Date of Evaluation:	
Name:	
Address:	
Date of Birth:	
Phone:	
Alternate Phone:	
Date of Birth:	
Primary MD:	
Referring MD:	
Name of Person Completing form:	
Relationship to Patient:	

1. Reason for referral:_____
2. Do you feel that your child has any difficulty producing specific speech sounds? ☐ **Yes** ☐ **No**
   If yes, list problem sounds:_____
3. Did your child develop speech and language appropriately? ☐ **Yes** ☐ **No**
   If no, please provide specifics:_____
   _____
4. Please indicate what your goals for speech therapy would be at this time:_____
   _____
5. Has your child been evaluated by an orthodontist? ☐ **Yes** ☐ **No**
6. Did the orthodontist provide information regarding plans for initiating orthodontic work?
   ☐ **Yes** ☐ **No**
7. Is your child in active orthodontic treatment? ☐ **Yes** ☐ **No**
8. When did your child's orthodontic treatment begin? _____
9. Please provide us with your child's medical history:_____

_____
_____

Child's Early Feeding History:

- Was the child bottle fed? ☐ **Yes** ☐ **No**
- If breast fed, how long? _____
- Did bottle-feeding continue beyond 12 months of age? ☐ **Yes** ☐ **No**
- Were there any feeding problems such a colic, special formula, difficulty making transition to table food? ☐ **Yes** ☐ **No**
- Did your child thumb suck? (If yes, how long?_____) ☐ **Yes** ☐ **No**
- Did your child use a pacifier? (If yes, How long?_____) ☐ **Yes** ☐ **No**
- If your child still uses a pacifier or sucks thumb, have you initiated efforts to decrease this behavior? ☐ **Yes** ☐ **No**

Speech

- Has your child ever been enrolled in speech therapy ☐ **Yes** ☐ **No**
- Does your child have difficulty saying s, sh, z, t, d, n, or l sounds? ☐ **Yes** ☐ **No**
- Do you notice that your child sticks his/her tongue out when talking? ☐ **Yes** ☐ **No**

Breathing Status:

- Is your child a mouth breather? ☐ **Yes** ☐ **No**
- Is it impossible for child to breathe freely through nose? ☐ **Yes** ☐ **No**
- Does your child have allergies, sinus problems, etc? ☐ **Yes** ☐ **No**
- Does your child still have his/her tonsils? ☐ **Yes** ☐ **No**
    - If yes are tonsils enlarged? ☐ **Yes** ☐ **No**

Associated Oral Behaviors:

- Does your child bite his/her fingernails? ☐ **Yes** ☐ **No**
- Does you child chew or suck on things such as pencils, knuckles, blankets? ☐ **Yes** ☐ **No**
- Does your child lick his/her lips frequently? ☐ **Yes** ☐ **No**
- Does you child prop chin when sitting at a table/desk? ☐ **Yes** ☐ **No**
- Does you child chew gum excessively? ☐ **Yes** ☐ **No**

Eating Habits:

- Does your child drink more than one glass of liquids with meals? ☐ **Yes** ☐ **No**
- Does your child appear to use liquids to wash down food? ☐ **Yes** ☐ **No**
- Is it difficult for your child to swallow dry foods without washing them down? ☐ **Yes** ☐ **No**
- Does your child eat ☐fast ☐slow?
- Does your child belch excessively after eating? ☐ **Yes** ☐ **No**
- Does your child have frequent digestive problems? ☐**Yes** ☐ **No**
- Does your child resist foods that are hard to chew? ☐ **Yes** ☐ **No**
- Does your child take excessive large bites of food ☐ **Yes** ☐ **No**
- Is it difficult for your child to swallow pills? ☐ **Yes** ☐ **No**

Family Dental History

- Do parents, siblings, or other relatives have similar problems with their teeth? ☐ **Yes** ☐ **No**

Does your child have any medical diagnosis (example: mental retardation, pervasive development disorder, Attention Deficit Disorder, etc.)

☐ **Yes** ☐ **No**

If yes, please list diagnosis:

_____

_____

AVAILABILITY:

Please indicate the days/times you are available to bring your child if he/she is recommended for speech/language therapy:

	Monday	Tuesday	Wednesday	Thursday	Friday
9-11:30am					
1-3:30pm					
3:30-5pm					
After 5pm					