

Patient History- Orofacial Myology

Date _____

Patient's Name _____ Age _____ Birth date _____

Present Height _____ Present Weight _____

Person(s) responsible for this account:

Name _____

Address _____

Telephone (home) _____

Email _____

Patient's information:

Address _____

Telephone (home) _____ work _____ cell _____

Email _____

Parent's information:

Mother's Name _____

Mother's Telephone (home) _____ work _____

Cell _____

Father's Name _____

Father's Telephone (home) _____ work _____

Cell _____

Family dentist _____

Orthodontist _____ Speech Pathologist _____

Family Physician _____

	Yes	No
(1) Is the patient in good health?	_____	_____
(2) Has there been any change in general health in the past year?	_____	_____
(3) Is the patient presently under a physician's care?	_____	_____
(4) Has the patient ever been seriously ill?	_____	_____
(5) Has the patient ever been hospitalized?	_____	_____
(6) Has the patient ever had surgery?	_____	_____
(7) Is the patient currently taking any medication?	_____	_____
If yes, which medications? _____		

(8) Is there a history of the following:

	Yes	No		Yes	No
Severe headaches	_____	_____	Rheumatic fever	_____	_____
Sinus trouble	_____	_____	Any joint problems	_____	_____
Frequent colds	_____	_____	Heart disease	_____	_____
Persistent cough	_____	_____	High blood pressure	_____	_____
Tonsillitis	_____	_____	Hepatitis	_____	_____
Frequent sore throat	_____	_____	Liver disorder	_____	_____
Operation or injury to teeth or jaws	_____	_____	Kidney disorder	_____	_____
Eye or ear problem	_____	_____	Diabetes	_____	_____
Allergies	_____	_____	Endocrine disturbance	_____	_____
name them _____			Dizziness/fainting	_____	_____
Asthma	_____	_____	Convulsions	_____	_____
Hay fever	_____	_____	Epilepsy	_____	_____
Anemia	_____	_____	Veneral disease	_____	_____
Bleeding problems	_____	_____	Speech problem	_____	_____
			Neurological problem	_____	_____

Tuberculosis	_____	_____	Behavioral problem	_____	_____
HIV positive	_____	_____	Eating disorders	_____	_____
Herpes	_____	_____	(anorexia or bulimia)	_____	_____
Emotional problem	_____	_____	Learning Disabilities	_____	_____

specify _____

(9) Has the patient ever experienced difficulty in doing or an unusual reaction to any of the following:

Swallowing pills	_____	_____	Swallowing liquids	_____	_____
Swallowing solids	_____	_____	Other	_____	_____
Medications	_____	_____	(explain)	_____	_____

When you are sitting with your jaw in its usual relaxed rest position, are your upper and lower teeth:

Together _____ Slightly apart _____

Where is your tongue usually resting in your mouth:

Against your upper teeth _____ Against your lower teeth _____ In between your upper teeth _____
 Not touching your teeth _____ On the floor of your mouth _____

	Yes	No
(10) Has patient ever had tubes placed in the ears?	_____	_____
(11) Have tonsils or adenoids been removed? If yes, when?	_____	_____
(12) Has patient ever had extensive X-rays for any condition?	_____	_____
(13) Has the patient ever been treated for a growth or tumor?	_____	_____
(14) Has the patient ever been in an auto accident? If yes, when?	_____	_____
(15) Have you ever been treated for HIV or AIDS related complex?	_____	_____
(16) Have you ever had speech therapy?	_____	_____

When? _____ How long? _____

(17) When was the patient's last dentist appointment _____

	Yes	No		Yes	No
Removal of teeth	_____	_____	Root canal work	_____	_____
Sensitive teeth	_____	_____	Oral surgery	_____	_____
Sore, bleeding gums	_____	_____	Other extensive	_____	_____
Gum treatment	_____	_____	treatment (explain)	_____	_____

(19) When are the patient's teeth brushed?

After breakfast	_____	_____	After lunch	_____	_____
After dinner	_____	_____	Before bed	_____	_____
Do you use dental floss	_____	_____			
How often? When?	_____				

(20) Is there any history of the following habits?

Thumbsucking	_____	_____	Chin propping with	_____	_____
Fingersucking	_____	_____	hand or fist	_____	_____
At what age did you quit	_____	_____	Cheek biting	_____	_____
Nail/lip biting (licking)	_____	_____	Does the patient chew	_____	_____
Blanket, knuckle, pen	_____	_____	gum excessively	_____	_____
Or pencil chewing	_____	_____	Other habits	_____	_____

(21) Does the patient play a musical instrument? (what and how often) _____

(22) Does the patient grind the teeth or clench the jaws at night?
 During the day? _____

(23) Does the patient breathe mainly through the mouth at night?
 During the day? _____

(24) Is there clicking or popping of the lower jaw joint? _____

(25) Is there pain or aching of lower jaw joint at any time? (where) _____

(26) Is there pain in the face, head or neck? _____

(27) Is there history of missing teeth in the family? _____

- (28) Does any member of the family have similar arrangement of teeth or jaws? _____
- (29) Has any member of the family had orthodontic treatment? _____
- (30) Are you aware that myotherapy appointments may infringe on school/work time _____
- (31) Is the patient's attitude toward participating in a therapy program.....
- | | Yes | No | | | |
|--|-------|-------|-----------------|-------|-------|
| Eagerness | _____ | _____ | Willingness | _____ | _____ |
| Complacency | _____ | _____ | Resignation | _____ | _____ |
| Antagonism | _____ | _____ | | | |
| (32) Does patient have frequent: | | | | | |
| Stomach cramps or gas | _____ | _____ | Hiccupping | _____ | _____ |
| Burping | _____ | _____ | Belching | _____ | _____ |
| Gastro intestinal distress | _____ | _____ | | | |
| (33) Who first noticed the need for orofacial myology (therapy) | | | | | |
| Dental Hygienist/Dentist | _____ | _____ | Parent | _____ | _____ |
| Physical Therapist | _____ | _____ | Nurse/Physician | _____ | _____ |
| Speech Pathologist | _____ | _____ | | | |
| (34) Why are you seeking treatment? | | | | | |
| Habit control/elimination | _____ | _____ | Better chewing | _____ | _____ |
| Pain control/elimination | _____ | _____ | Better speech | _____ | _____ |
| On advice of dentist | _____ | _____ | Appearance | _____ | _____ |
| On advice of friends | _____ | _____ | Other (explain) | _____ | _____ |
| (35) Do you understand therapy involves behavioral changes that are NOT under control of the therapist | | | | _____ | _____ |
| (36) Do you understand the Patient is responsible for compliance? (following directions and exercises) | | | | _____ | _____ |
| (37) Do you understand that lack of cooperation may delay progress and/or have an effect on therapy results? | | | | _____ | _____ |

Do you understand uncorrected finger, thumb, tongue thrusting, grinding/clenching or similar pressure habits; unusual hereditary skeletal patterns; insufficient or undesirable growth patterns may have an effect on long term success of therapy? _____(yes) _____(no)

I hereby grant permission to the practice of **Dr. Gail A. Kopin, RDH, COM, N.D.** also known as Alternative Health Associates, for the use of this patient's orofacial myology records for professional teaching, educational and publication purposes, so long as reasonable precautions are taken to guard against the disclosure of the patient's identity.

I, also, grant permission for the release of information for insurance purposes or progress reports to my listed health care providers.

Appointments: failed visits will pay for entire visit if we can not re-fill pre-arranged appointments.

Financial Arrangements:

Welcome and clear discussions of services and fees are encouraged prior to treatment. However, we do consider each patient primarily responsible for his or her account. Assignment of insurance benefits are generally not accepted. We will prepare necessary forms or reports to help you obtain benefits from your insurance carrier. Services are not rendered on the basis that insurance carriers will pay all fees. Payment is due at the time services are provided. Extended payment plans may be arranged if needed.

I acknowledge I have read or had read to me the contents of this form and understand what is stated.

Signature _____ Date _____

Relationship to patient _____

Doctor/Therapist Reviewer _____