Advanced Lightwire Functional Appliance

EVALUATION

Name: _____ Age: _____ DOB:_____ Date: _____

Chief Complaint(s) : _____

1. Describe pregnancy: _____
2. Describe birth delivery: (c-section, prolonged, epidural, induced, breach, forceps, bruising etc.)

   _____
3. Breast fed? how long? YES NO Explain: _____
4. Painful, noisy, problems latching with breast feeding? YES NO

   Explain: _____
5. History of frenectomy or diagnosed tongue tie? Explain: _____
6. Visit(s) with lactation consultant? YES NO Explain: _____
7. Did the baby experience any colic? YES NO Explain: _____
8. Any bottle feeding? YES NO Explain: _____
9. At what age were solid foods introduced? _____
10. Crawling at what age, describe crawl? _____
11. Walking at what age, describe? _____
12. Any trouble with fine or gross motor skill development? (tying shoes, coordination, etc.) YES NO

    Explain: _____
13. Any diseases or illnesses? _____
14. Any problems with skin rashes or eczema? _____
15. Vaccinations (normal, delayed schedule, none)? _____
16. Describe any reactions to the vaccinations? _____
17. History of any medications or antibiotics? _____
18. Any sucking habits? (fingers, nails, shirts, blankets, cheeks, pencils, etc.) _____

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19. Sensory issues? (photo sensitive, noise, textures, tags, etc.) YES NO Explain: _____
20. Picky eater? YES NO Describe diet: _____
21. Any gagging? (pills, foods, drinks, etc.) _____
22. Describe any digestive problems? _____
23. Any scars, surgeries, falls or car accidents? Explain: _____

_____

24. Describe sleep? (how long, restless, interrupted, difficulty to fall asleep or wake up, etc.)

_____

25. History of night terrors? _____
26. Bed wetting issues? _____
27. Sleep posture? (on back, side, stomach, etc.) _____
28. Teeth grinding? YES NO Explain: _____
29. Snoring? YES NO Explain: _____
30. Breath holding? YES NO Explain:_____
31. Headaches? YES NO Explain: _____
32. TMD pain, clicking, ringing of the ears? YES NO Explain: _____
33. History of ear infections or tubes? YES NO Explain: _____
34. History of chronic congestion or sinusitis? YES NO Explain: _____
35. Any problems with tonsils and adenoids?_____
36. History of Asthma and/or inhaler?_____
37. Breathing? (mouth, nasal, congested, difficulty, wheezing, etc.) _____
38. Mouth open at night during sleep? _____
39. Any allergies? YES NO Explain: _____
40. Any pets? YES NO Explain: _____

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41. Any behavior or social issues? (Autism Spectrum, ADD, etc.)
    _____
42. How are peer-peer interactions, describe: _____
43. Any academic or learning issues? _____
44. Speech issues? (lisp, speech therapy, etc.) _____
45. Activities, sports, musical instruments? _____
46. Any history of previous orthodontics? Explain: _____
47. Problems with cavities in the past? _____

CLINICAL ASSESSMENT (DONE BY DENTIST/STAFF)

48. Posture assessment: (forward head posture, slouched, limp, etc.) _____
49. Gummy smile? YES NO
50. Lip posture (lip seal, sucked in lower lip, etc)?
51. Palate size and shape? _____
52. Diastema's present? YES NO Where: _____
53. Maxillary bone restriction? _____
54. Tongue position? (low tongue posture, anterior thrusts, lateral thrusts, etc.) _____
55. Maxillary frenum: NORMAL MILD MODERATE HEAVY
56. Lingual frenum: NORMAL MILD MODERATE HEAVY
57. Crowding of maxillary or mandibular teeth? _____
58. Open bite? YES NO
59. Crossbites? YES NO Explain: _____

Attitude: Patient:_____ Parent: _____

Patient Goals: _____