Oral Function Questionnaire *(patients age 2 and older)*

Patient's Name _____ Birth Date _____ Today's Date _____

Guardian's Name _____

Medical Issues _____ Medications _____

Allergies _____ History of previous clip or release of tongue? _____ (date)

Have you or 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
_____ % 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

_____ Successfully breastfed? How long? _____
_____ Bottle fed exclusively
_____ Used a pacifier for more than 6 months
_____ Frustration when eating
_____ Difficulty transitioning to solid foods
_____ Slow eater (doesn't finish meals)
_____ Grazes on food throughout the day
_____ Packing food in cheeks like a chipmunk
_____ Picky with textures (which?) _____
_____ Choking or gagging on food
_____ Spits out food
_____ 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 dribbling out of mouth
_____ Poor supply
_____ Nipple shield required for nursing
_____ Clicking or smacking noise when eating
_____ Other:

Sleep Issues

_____ Sleeps in strange positions
_____ Kicks and flails around at night
_____ 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 day
_____ Tonsils or adenoids previously removed
_____ Ear tubes previously
_____ History of reflux (medicated or not)
_____ Constipation

_____ Signs or diagnosis of hyperactivity (ADD/ADHD)
_____ Falls asleep watching TV
_____ Wakes up in the morning with a headache
_____ Aggressive behavior
_____ Irritability and/or anger
_____ Taking any medicine for behavior modification
_____ Dark circles under his or her eyes

Anything else we should know:

Pediatrician's Name _____

Speech Therapist (if applicable) _____

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