Clinic Intake Form

Medical & Family History

Patient Name: ______________________________ **DOB:** ____________________

Medical History.
Who is on your medical team? (Please check all that apply.)

- ☐ Speech Therapist (SLP)
- ☐ Physical Therapist (PT)
- ☐ Occupational Therapist (OT)
- ☐ ABA Therapist
- ☐ Counselor
- ☐ Lactation Consultant / IBCLC
- ☐ Gastroenterologist (GI)
- ☐ Dentist (DDS/DMD)
- ☐ Certified Professional / Nurse Midwife
- ☐ Neurologist
- ☐ Allergist
- ☐ Orthodontist
- ☐ Special Education Teacher
- ☐ OB/GYN
- ☐ Dietician / RD
- ☐ Otolaryngologist / ENT
- ☐ Chiropractor (DC)
- ☐ Pulmonologist
- ☐ Sleep Medicine
- ☐ Osteopath (DO)
- ☐ Massage Therapist (LMT)
- ☐ Craniosacral Therapist (CST)
- ☐ Other: ____________________

Does the patient have a medical diagnosis? ☐ Yes ☐ No

If yes, Please list: ____

Has the patient been hospitalized? ☐ Yes ☐ No

If yes, Please explain: ____

Does the patient take any medications? ☐ Yes ☐ No

If yes, please list below or provide a list to copy.

Medication	Reason	Dosage	Frequency

Clinic Intake Form

Medical & Family History

Does the patient have any allergies? ☐ Yes ☐ No

If yes, please list: ____________________

Has the patient experienced any of the following?

- ☐ Frequent Colds
- ☐ Failure to Thrive
- ☐ Hearing Issues
- ☐ Seizures
- ☐ Frequent Congestion
- ☐ Lip, Tongue, or Cheek Release
- ☐ Constipation
- ☐ Restless Sleep
- ☐ Asthma
- ☐ Tracheostomy
- ☐ Sores
- ☐ Jaw Pain
- ☐ Cardiac Issues
- ☐ Frequent Headaches
- ☐ Reflux / Frequent Spit-up (GERD/LPR)
- ☐ Jaw Clicking
- ☐ Mouth Breathing
- ☐ Migraines
- ☐ Bed Wetting
- ☐ None
- ☐ Tonsil/Adenoid Removal
- ☐ Picky Eating
- ☐ Recurrent Ear Infections
- ☐ Imaging: ____________________
- ☐ Surgery: ____________________

Other: ____________________

Dental History
Does the dentist have concerns about structure? (Check all that apply)

- ☐ High Palate
- ☐ Cavities
- ☐ Tongue Tie
- ☐ Palatal Expansion
- ☐ Clenching
- ☐ Plaque
- ☐ Lip Tie
- ☐ Orthodontic Relapse
- ☐ Grinding
- ☐ Thrush
- ☐ Cheek Tie
- ☐ Braces
- ☐ None
- ☐ Other: ____________________

Family History
If under 18, Who does the child live with?

- ☐ Both Parents
- ☐ Mother
- ☐ Father
- ☐ Grandparents
- ☐ Other: ____________________

Clinic Intake Form

Medical & Family History

Does the patient have siblings?

- ☐ Yes; How Many ________ Ages ____
- ☐ No

What diseases or disorders run in the family? (Check all that apply)

☐ ADD/ADHD	☐ Diabetes	☐ Stuttering	☐ Hearing Loss
☐ Anxiety	☐ Thyroid Issue	☐ Stroke	☐ Allergies
☐ Autism	☐ Asthma	☐ Learning Disability	☐ None
☐ Heart Disease	☐ Dental Issues	☐ Parkinson's Disease	☐ Other: ________________________
☐ Dyslexia	☐ Depression	☐ Pre-Eclampsia	