Columbia Dental Group

MYOLOGY EVALUATION

First Name: Last Name:

Date of Birth: Today's Date:

Responsible Party (if someone other than the patient):

Street Address:

City, State, Zip:

Phone: Email:

Occupation: Referred by:

Physician/Pediatrician
Name/ Contact Information:

GENERAL MEDICAL HISTORY

- ☐ Apnea/ UARS
- ☐ Recurrent Upper Respiratory Infections
- ☐ Recurrent Strep Throat
- ☐ Deviated Septum
- ☐ Nasal Polyps
- ☐ Turbinate Reduction
- ☐ Sleep Disorders
- ☐ History of Enlarged Tonsils
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Depression
- ☐ Middle Ear Issues
- ☐ Myringotomy (ear tubes)
- ☐ Autism
- ☐ Bells Palsy
- ☐ Hypertenstion
- ☐ Diabetes
- ☐ Recurrent Sinus Infections
- ☐ COPD
- ☐ TB
- ☐ ADD
- ☐ ADHD
- ☐ Airway Surgeries
- ☐ Chronic Nasal Congestion
- ☐ Visual Processing Issues
- ☐ Tonsillectomy: age___
- ☐ Removal of Adenoids:age_____
- ☐ Recurrent Ear Infections
- ☐ Cancer
- ☐ Auditory Processing Issues
- ☐ Down Syndrome
- ☐ Heart Issues
- ☐ Irregular Heartbeat
- ☐ Asthma

Surgeries:_____

Other/Comments:_____

MYOLOGY EVALUATION

PAIN DISORDERS:

- ☐ Joint/Arthritis
- ☐ Rheum Arthritis
- ☐ Jaw/TMD Pain
- ☐ Fibromyalgia.
- ☐ Cervical Disorder
- ☐ Lumbar Disorders
- ☐ Muscular Pain
- ☐ Tri-Neuralgia
- ☐ Other/Comments: _____

Have you ever used an occlusal guard/night guard? ☐ Yes ☐ No

TMJ or Facial Pain: Pain Scale: (1-10) _____

Frequency (how often):_____

How do you manage your pain?: ☐ Controlled with OTC ☐ Controlled with RX _____

Other control methods: _____

HEADACHES

Have you ever used an occlusal guard/night guard? ☐ Yes ☐ No

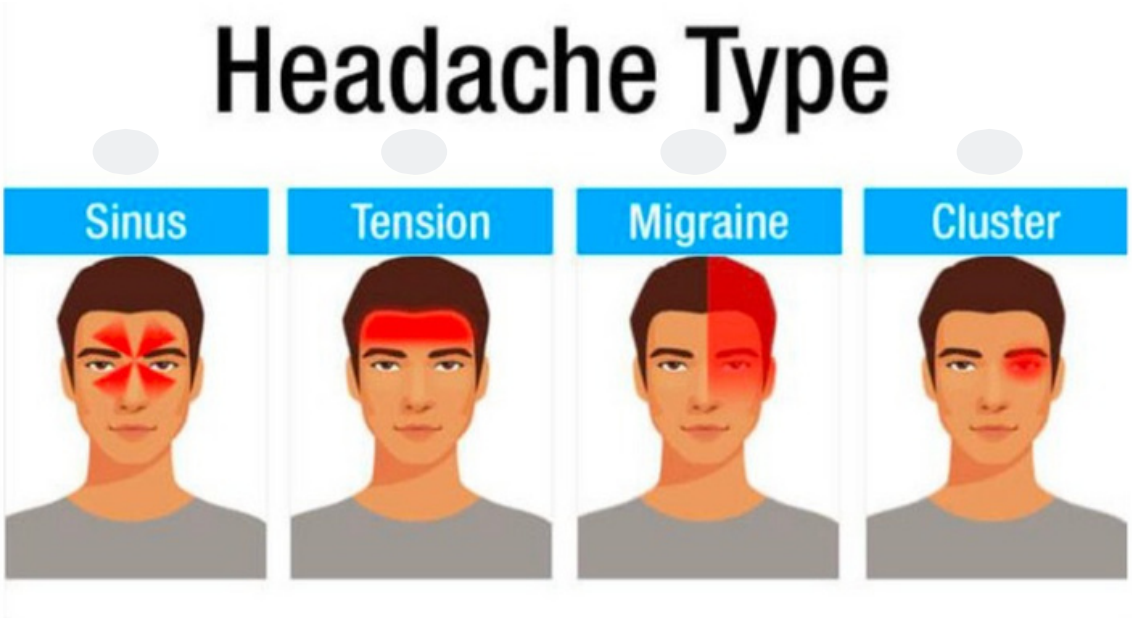
TMJ or Facial Pain, frequency: _____

Pain Scale: (1-10) ____

How do you manage your pain? ☐ Controlled with OTC ☐ Controlled with RX _____

Other control methods: _____

Check headache type:



MYOLOGY EVALUATION

ALLERGIES:

☐ None Reported ☐ Year Round ☐ Mild ☐ Moderate ☐ Severe

☐ Controlled with OTC ☐ Controlled with RX Seasonal/Environmental ☐ Other control methods

PRENATAL HISTORY:

☐ WNL ☐ Drug exposure ☐ Smoking Complications ☐ Alcohol exposure ☐ Preeclampsia

☐ Other: _____

BIRTH HISTORY:

☐ WNL (born circa 40 wks) ☐ Early Delivery ☐ Complications ☐ C-Section ☐ Extensive Labor

☐ Forceps ☐ Preterm Labor ☐ Breech ☐ Induction ☐ Extensive Labor ☐ Terticollis ☐ Pitocin

EARLY FEEDING HISTORY:

☐ Breastfed Duration _____ ☐ Difficulty with Latch ☐ Sore or bleeding nipples ☐ Pulled off in frustration

☐ Bottle-fed

EARLY FEEDING SKILLS:

☐ Acid Reflux ☐ Frequent belching ☐ Vomiting / Gagging

☐ Gastro-intestinal discomfort/Distention/Gas/Constipation ☐ Diagnosed Feeding Disorder

Describe_____ Treatment:_____

FINE MOTOR DEVELOPMENT:

☐ WNL (eg. drawing) ☐ Delayed

GROSS MOTOR DEVELOPMENT:

☐ WNL (eg. rolling, crawling, walking) ☐ Delayed

REPORTED FOOD AVERSIONS:

☐ All Meats ☐ Fibrous Meats ☐ Raw Vegetables ☐ Fruits ☐ Cooked Vegetable

☐ Breads ☐ Textures ☐ Spicy ☐ Can only tolerate Soft Solids

Other:_____

SPECIAL DIET CONSIDERATIONS:

☐ Gluten Free ☐ Dairy Free ☐ Egg ☐ Red Dye ☐ Paleo ☐ Vegan ☐ Kosher

Other: _____

GENERALIZED COMPLAINTS:

☐ Drinking ☐ Chewing ☐ Swallowing ☐ Throat ☐ Stomach

MYOLOGY EVALUATION

REPORTED CHEWING PATTERNS:

☐ Described as Picky Eater ☐ Noisy Eater ☐ Audible ☐ Gulping ☐ Messy ☐ Gags Easily

☐ Chews w/ Lips Apart ☐ Facial Discomfort ☐ Coughs After Meals ☐ Relies Liquids w/ Meals

☐ Dental Factors Resulting in Adaptations ☐ Saliva Management ☐ Drooling

Other:_____

PILL SWALLOWS:

Large Pills ☐ Capable ☐ W/ Difficulty ☐ Incapable

Small Pills ☐ Capable ☐ W/ Difficulty ☐ Incapable

☐ Never Attempted Comments:_____

SENSITIVITIES:

☐ Pain Sensitivities ☐ Tags/Cloth Textures ☐ Temperatures ☐ Sensitive to Touch

☐ Avoids Spicy Foods ☐ Enjoys Spicy Foods ☐ Proprioception Difficulties ☐ Skin Neuralgia

Other:

SLEEP QUALITY CONSIDERATIONS:

Do you snore? ☐ Yes ☐ No ☐ Unknown Average Sleep per Night (in hours):_____

Do you wake up refreshed? ☐ Yes ☐ No

Do you suffer from ch ronic fatigue or feelings of constantly being tired? ☐ Yes ☐ No

Have you been tested for sleep apnea (OSA)? ☐ Yes ☐ No

What was your diagnosis?_____

Do you use a CPAP or dental sleep appliance? ☐ Yes ☐ No ☐ CPAP ☐ Dental Appliance

Frequency of CPAP/dental appliance use: ☐ Daily ☐ Intermittantly

Comments:_____

SLEEP DISTURBANCES:

☐ Bedwetting ☐ Sleep talking ☐ Restless Leg Syndrome ☐ Night terrors/nightmares Tossing/Turning

☐ Sleep walking ☐ Drooling ☐ Sleeping in strange body positions Have to be upright to sleep

☐ Grinds teeth

NOXIOUS HABITS:

☐ Digit Sucking ☐ Current? Age Resolved___ ☐ Pacifier Usage ☐ Current? Age Resolved___

☐ Nail Biting ☐ Current? Age Resolved___ ☐ Hair Twisting ☐ Current? Age Resolved ___

☐ Trichotillomania ☐ Current? Age Resolved___ ☐ Tongue Sucking ☐ Current? Age Resolved__

☐ Object Chewing ☐ Current? Age Resolved___

ORAL FAMILY HISTORY:

☐ Tongue Tie ☐ No Known Hx Family Member_____

☐ Lip-Tie ☐ No Known Hx Family Member_____ Cleft

☐ Palate No Known Hx Family Member_____

☐ Orthodontia ☐ No Known Hx Family Member_____

Speech Disturbance? ☐ Yes ☐ No Other:_____

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MYOLOGY EVALUATION

GENERAL DENTAL HISTORY:

☐ No dental Treatment to Date ☐ Cavities ☐ Primary Tooth Extractions
☐ Removal of Bicuspids / 3rd Molars ☐ Gum Disease ☐ Bleeding Gums Gum Grafts/
☐ Recession Other:_____

ORTHODONTIA HISTORY:

☐ No Orthodontic Treatment to Date ☐ Current Orthodontic Treatment
☐ Phase I Orthodontic Treatment ☐ Orthodontic Appliance Therapy (prev/cur)
☐ Previous Palatal Expansion ☐ Current Palatal Expander
☐ Reports Orthodontic Relapse ☐ Head Gear
☐ Splint Therapy ☐ Completed Orthodontics
☐ Invisalign (previous/current) ☐ Retainers
☐ TMD ☐ TMD Therapy Appliances
☐ Removable Appliance Other:_____

SPEECH DEVELOPMENT:

☐ Reported WNL ☐ Late Talker ☐ Mumbles ☐ History of Speech Therapy
☐ Current Speech Therapy ☐ Further Speech/Language Evaluation Required
Sound errors:
☐ T ☐ N ☐ L ☐ D ☐ S ☐ SH ☐ CH ☐ R

SPEECH THERAPY:

Comments:_____

POSTURE:

☐ Forward Head ☐ Shoulder Height ☐ Rolled Shoulders ☐ Head Tilt
☐ Hips Feet Walking ☐ Toes ☐ Heels Foot Position on Standing

SPORTS/ACTIVITIES/HOBBIES:

Sports:_____ Hobbies:_____

Other:_____

POTENTIAL FOR THERAPY HOME CARE COMPLIANCE:

☐ Self Starter ☐ Capable of Following Directions Home
☐ Will need Parent/Care Taker Assistance ☐ Care will be Limited

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QUESTIONNAIRE

1. NASAL BREATHING DIFFICULTY:

Rate from 0-100 how difficult it is to breathe through the nose (usually or most commonly)?

Score: _____

2. COMPLETE THE FOLLOWING QUESTIONS, CHOOSING FROM 1-4 FOR EACH ROW/QUESTION (CIRCLE)

	Question	1	2	3	4
Nasal vs. Mouth Breathing	**How often do you mouth breathe while awake?**	Primarily nasal breathing: Rarely to never mouth breathes when awake.	Sometimes mouth breathes when awake.	Often mouth breathes when awake.	Almost always mouth breathes when awake.
	How often do you mouth breathe while asleep?	Primarily nasal breathing: Rarely to never mouth breathes when asleep.	Sometimes mouth breathes when asleep.	Often mouth breathes when asleep.	Almost always mouth breathes when asleep.
Posture	**Do you slouch while awake?**	Rarely slouches.	Sometimes slouches.	Often slouches.	Almost always slouches.
	Do you sleep on your back, or on your sides + stomach?	Primarily sleeps on back.	Sleeps on back> more than sides or stomach.	Sleeps on sides/stomach> more than back.	Primarily sleeps on sides or stomach.
Psychosocial (CNS)	**Do you have any difficulty concentrating or is it easy for you to focus?**	Rarely to never has difficulty concentration. Easy to focus.	Sometimes has difficulty concentrating. Somewhat difficult to focus.	Often has difficulty concentrating. Moderately difficult to focus.	Almost always has difficulty concentrating. Very difficult to focus.
	Do you generally feel more relaxed or more anxious?	Almost always relaxed. Rarely feels stressed.	Often relaxed. Sometimes feels stressed.	Sometimes feels relaxed. Often feels stressed.	Rarely feels relaxed. Almost always stressed.
Tongue Resting Position	**Where do you feel that your tongue rests in your mouth?**	Entire tongue usually rests up along palate.	The tip of the tongue usually rests up on the palate.	The tongue usually rests in the middle against the teeth.	The tongue usually rests on the floor of the mouth

3. CHIEF COMPLAINT FOR THERAPY:

- ☐ Oromyofascial dysfunction Tongue-Tie
- ☐ Mouth Breathing
- ☐ Obstructive Sleep Apnea
- ☐ Sleep-Disordered Breathing
- ☐ Other_____

The Self Evaluation of Breathing Questionnaire

Scoring: (0) never/not true at all; (1) occasionally/a bit true; (2) frequently-mostly true; and, (3) very frequently/very true

1.I get easily breathless out of proportion to my fitness	0	1	2	3
2.I notice myself breathing shallowly	0	1	2	3
3.I get short of breath reading and talking	0	1	2	3
4.I notice myself sighing	0	1	2	3
5.I notice myself yawning	0	1	2	3
6.I feel I cannot get a deep or satisfying breath	0	1	2	3
7.I notice that I am breathing irregularly	0	1	2	3
8.My breathing feels stuck or restricted	0	1	2	3
9.My ribcage feels tight and cannot expand	0	1	2	3
10.I notice myself breathing quickly	0	1	2	3
11.I get breathless when I'm anxious	0	1	2	3
12.I find myself holding my breath	0	1	2	3
13.I feel breathless in association with other physical symptoms	0	1	2	3
14.I have trouble coordinating my breathing when I am speaking	0	1	2	3
15.I can't catch my breath	0	1	2	3
16.I feel that the air is stuffy, as if not enough air is in the room	0	1	2	3
17.I get breathless even when I am resting	0	1	2	3
18.My breath feels like it does not go in all the way	0	1	2	3
19.My breath feels like it does not go out all the way	0	1	2	3
20.My breathing is heavy	0	1	2	3
21.I feel that I am breathing more	0	1	2	3
22.My breathing requires work	0	1	2	3
23.My breathing requires effort	0	1	2	3
24.I find myself breathing through my mouth during the day	0	1	2	3
25.I breathe through my mouth at night while I sleep	0	1	2	3
Total				

A score greater than 11 may indicate problems with your breathing.

Which position do you typically sleep in ?

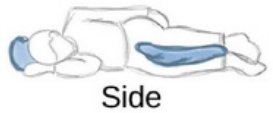
Rarely ○ Often ○ Always ○

Stomach

Rarely ○ Often ○ Always ○

Back

Rarely ○ Often ○ Always ○



Side

Columbia Dental Group

MYOLOGY EVALUATION

AUTHORIZATION AND CONSENT TO USE PHOTOCRAPH OR VIDEO RECORDINGS

Name: _____ Date of Birth:___/___/_____

I, the undersigned, do hereby consent and agree that Dr. Sarah Clayton and its employees, and/or agents have the right to take photographs, video, or digital recording of me or my dependent and to use these in any and all media, including educational materials, informational and conference presentations, social media, website, before/after photos etc.

(Mark your choice below)

[ ] YES - Including full face.
[ ] YES - But please exclude any recognizable facial features.
[ ] NO - Photographs may only be used for medical record keeping and treatment planning only.

I further consent that my name and identity may be revealed therein or by descriptive text or commentary.
(Mark your choice below)

[ ] YES- Use my name.
[ ] NO- I prefer to remain anonymous.

Risks and Limitations Of Myofunctional Therapy
Successful myofunctional therapy treatment is a partnership between the therapist and the patient. Your health practitioners, myofunctional therapist, and all of the team involved are dedicated to achieving the best possible result. As a general rule, informed and cooperative patients can achieve incredible and very successful results from their therapy. While recognizing the benefits of a healthy breathing, swallowing pattern, proper tone and functioning of the face and mouth muscles, and a correct resting posture for the lips and tongue, you should also be aware that as with any form of treatment there are limitations and risks. These are seldom serious enough to indicate that you should not undergo treatment, however, it is important for you to know and understand this information.
Myofunctional therapy is a specialized treatment that includes the diagnosis, prevention, interception, and correction of myofunctional disorders, as well as habits associated with or causing these muscular and breathing concerns.
*** I understand the Risks and Limitations of Myofunctional Therapy**

_____
*I consent to sharing information provided here.

Name of Authorizing Individual:_____ Relationship to Patient: _____

Signature:_____Date:_____

If this release is obtained from a patient under the age of 18, then the signature of the parent or legal guardian is required.

Columbia Dental Group

MYOLOGY EVALUATION

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

Name: _____ Date of Birth: _____/____/_____

Release of Information:
I hereby authorize Dr. Sarah Clayton, and affiliates, employees, or agents to release any personal health information (e.g., information relating to the diagnosis, records, treatment, claims payment,and health care services) provided or to be provided to:

[ ] Parent/ Spouse / Relative_____
[ ] Referring Provider _____
[ ] Primary Care Doctor_____
[ ] Other Consultants_____

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]

I do not authorize Dr. Sarah Clayton, or affiliates to release any medical information.
***This Release of Information will remain in effect until terminated by me in writing.**

Messages
Please call: [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time) _____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Columbia Dental Group

MYOLOGY EVALUATION

Results Of Treatment And Commitment To The Program
Myofunctional therapy treatment usually proceeds as planned, and we intend to do everything we can to help you achieve the best results possible. However, because this type of treatment involves patient participation and at-home involvement, we cannot guarantee that you will be completely satisfied with the results if the assignments and exercises given are not completed outside of your scheduled appointments.

The success of your therapy depends on the level of cooperation and involvement that you are willing to take at home. In order to receive optimal results, it is recommended that patients practice their exercises for at least five minutes, twice per day.

Any therapy program requires commitment and long-term dedication. If you decide at any point during treatment that you'd like to stop the program, you will have the option to take a break and restart at a later stage, but no refunds will be offered except in special circumstances
.
*** I understand the results of treatment and commitment to the program**

_____
*I consent to sharing information provided here.

Parent Participation for Patients under the age of 18
When it comes to working with children, parent involvement is mandatory. A parent MUST be present at every session and actively involved in taking notes, practicing exercises, or doing therapy alongside your child.

We highly recommend that parents take an active role in practicing the exercises with their children outside of therapy sessions.

Myofunctional therapy is NOT successful for children when parents are not involved in the process. It is crucial to your child's success to have parental guidance, motivation, and accountability outside of their treatment sessions.

I understand I must be present during my child's myofunctional therapy sessions and actively involved in the therapy process.

_____
*I consent to sharing information provided here.

I am an adult and this does not apply to me.

_____
*I consent to sharing information provided here.

CANCELLATION POLICY
Short notice cancellations or missed appointments significantly affect our practice, often leaving us with appointment slots that are unable to be filled.
We understand that situations and circumstances can often arise unexpectedly, and we try to be as accommodating as possible, however, we ask that you please provide us with least a **72 hour** advance notice whenever possible to avoid a fee.

For any appointments that are canceled or changed with less than 48 hours of notice, as well as any missed appointments (no-shows), a cancellation fee may be applied.
* I understand the cancellation policy.

_____
*I consent to sharing information provided here.