Child/ Teenager Tongue- Tie Questionnaire

Today's Date_____

CHILD/TEENAGER (please circle):

Patient's Name: _____ Birth Date: _____

Form Filled out by: _____ Relationship to Child: _____

Pediatrician: _____

Main Concern:_____

Previous clip or release of tongue? _____ (date)

Has **YOUR CHILD OR TEENAGER** experienced any of the following? Please elaborate if needed.

Speech

_____Frustration with communication
_____Difficult to understand by parents/outsiders
_____Trouble with sounds (which?)_____
_____Speech delay (when?)_____
_____Stuttering
_____Choking or gagging on food
_____Mumbling or speaking softly
_____ "Baby talk"

Feeding

_____Frustration with eating
_____Difficulty transitioning to solid foods
_____Slow eater
_____Packing food in cheeks like a chipmunk
_____Picky with textures (which?)_____
_____Spits out food
_____Prefers pureed food

Sleep Issues

_____Wakes easily or often
_____Wets the bed
_____Wakes up tired and not refreshed
_____Sleeps with mouth open
_____Snores while asleep (how often?)_____
_____Gasps for air or stops breathing (sleep apnea)
_____Grinds teeth while sleeping (how often) _____

Other related issues

_____Neck or shoulder pain or tension
_____TMJ pain, clicking, popping
_____Headaches or migraines
_____Strong gag reflex
_____Mouth open/mouth breathing during the day
_____Tonsils and adenoids removed previously
_____Ear tubes previously
_____Reflux (medicated or not)

Is your **CHILD or TEENAGER** in speech therapy? **YES/NO**

If yes, how long?_____

Private Therapist or School Therapist **(please circle)**

Speech Therapist: _____ Phone Number: _____