Orange County Pediatric Dentistry
Dr. Dayna Olstein
Dr. Arielle Rolon

Child Assessment Sheet

PATIENT INFORMATION							
First Name		**Last Name**		**Birth Date**		**Age**	
Medical Issues							
Medications Taking							
Allergies							
Previous clip of tongue/lip?	❑ Yes ❑ No	**When**		**Where**			

Has 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
- ❑ % percent 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 Talks" or uses baby voice

Feeding

- ❑ Frustration when eating
- ❑ Difficulty transitioning to solid foods
- ❑ Slow eater (doesn't finish meals)
- ❑ Small appetite/ Trouble gaining weight
- ❑ Grazes on food throughout the day
- ❑ Packing food in cheeks like a chipmunk
- ❑ Picky eater/ with textures (which?) _____
- ❑ Choking or gagging on food
- ❑ Spits out food
- ❑ Won't try new foods
- ❑ Constipation
- ❑ Reflux (medicated or not)
- ❑ Affects family dynamics (can't eat out, etc.)

Nursing or Bottle-Feeding Issues as a Baby

- ❑ Painful nursing or shallow latch
- ❑ Poor weight gain
- ❑ Reflux or spitting up
- ❑ Gassy (tooted a lot) as a baby
- ❑ Milked leaked out of mouth/ messy eater
- ❑ Poor milk supply
- ❑ Nipple shield needed for nursing
- ❑ Clicking or smacking noise when eating
- ❑ Cried a lot/ colic as baby
- ❑ Other _____

Sleep Issues

- ❑ Sleeps in strange positions
- ❑ Sleeps restlessly (moves a lot)
- ❑ 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
- ❑ Prolonged thumb sucking/ pacifier use
- ❑ Mouth open/ mouth breathing during the day
- ❑ Tonsils or adenoids removed previously
- ❑ Ear tubes previously/ lots of ear infections
- ❑ Hyperactivity/ Inattention

Lip-Tie Issues

- ❑ Difficult or fights to brush top teeth
- ❑ Top teeth don't show when smiling
- ❑ Gap between two front teeth
- ❑ Cavities on front teeth
- ❑ Trouble eating from a spoon/ flips spoon over
- ❑ Trouble with B, P, M or W sounds

Any Other Issues or Concerns	
Primary Care Provider	
Chiropractor/ PT/ CST	
Speech/ Feeding Therapist	
Other Therapist/ Provider	
Who referred you to us?	

FORM COMPLETION

Signature of Patient, Parent or Guardian		**Date**	
Form signed by		**Relationship to Patient**	
Doctor's Signature			