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

Tongue Restriction Questionnaire (TRQ)

PATIENT INFORMATION

First Name		Last Name		Gender		DOB	

Please check any issues that apply to help us determine if a tongue restriction may be present.

Baby Issues (Past or Present)

- ❑ Painful nursing or shallow latch
- ❑ Difficulty bottle-feeding
- ❑ Slow or poor weight gain
- ❑ Reflux or spitting up often
- ❑ Excessive gassiness or fussiness as a baby
- ❑ Prolonged feeding time at the breast or on the bottle
- ❑ Milk dribbling out of the mouth when eating
- ❑ Clicking or smacking noise when eating

Child to Adult Issues

- ❑ Frustration with communication
- ❑ Trouble with speech sounds, hard to understand, or mumbling
- ❑ Speech delay
- ❑ Slow eater or trouble finishing a meal
- ❑ Choking or gagging on liquids or foods
- ❑ Picky eater, especially with textures (e.g. meat, mashed potatoes)
- ❑ Spitting out food or packing food in cheeks
- ❑ Crooked, crowded teeth, or high arched palate
- ❑ Thumb or finger sucking or prolonged pacifier use
- ❑ Restless sleep (kicking or moving while asleep)
- ❑ Grinds teeth at night
- ❑ Sleeps with mouth open
- ❑ Snores (quiet or loud)
- ❑ Jaw joint (TMJ) issues (popping, clicking, or pain)
- ❑ Frequent headaches or neck pain
- ❑ Mouth breathing during the day
- ❑ Enlarged tonsils and/or adenoids
- ❑ Recurrent ear infections
- ❑ Hyperactivity or inattention
- ❑ Frequent sinus issues/upper respiratory infections

To be completed by healthcare provider:

Tongue Elevation Exam

❑ Grade 1 (>80%) ❑ Grade 2 (50-80%) ❑ Grade 3 (<50%) ❑ Grade 4 (<25%)

Referral Recommended

❑ YES ❑ NO ❑ MAYBE

FORM COMPLETION

Signature of Patient, Parent or Guardian:		Date:	

IF PATIENT IS A MINOR

Form signed by:		Relationship to Patient:	