9885 E. 116th St., #100, Fishers, IN 46037
317-842-8453
www.babytoothcenter.com

# TONGUE TIE QUESTIONNAIRE

Patient's Name_____DOB:_____Age_____
Current Medications_____
Allergies_____

**Has your child experience any of the following issues? Please check or elaborate as needed:**

## Speech

__Frustration with communication
__Difficulty speaking fast
__Speech Delay? When? _____
__Mumbling, speaking softly, "baby talk"?
__Trouble with sounds? Which ones?_____
__Difficult to understand by parents/outsiders
__Difficult getting words out (groping for words)
__Speech Therapy? How long?_____
% of time you understand your child_____

## Feeding

__ Frustration when eating
__Slow eater (doesn't finish meals)
__Packing food in cheeks
__Spits out foods
__Picky eater with textures? Describe_____
__Difficulty transitioning to solid foods
__Grazes on food throughout the day
__Choking or gags on food
__Won't try new foods
Other:_____

## Nursing or Bottle Feeding Issues as a Baby

__Painful nursing/shallow latch
__Reflux/Spitting Up
__Milk dribbling out of mouth
__Nipple shield required for nursing
__Poor weight gain
__Unable to hold pacifier
__Poor Supply
__Clicking or smacking noise when eating
Other:_____


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## Sleep Issues

__Sleeps in strange positions
__Wakes easily or often
__Wakes up tired and not refreshed
__Sleeps with mouth open
__Snores while sleeping? How often_____
__Kicks and flails around at night
__Wets the bed
__Grinds teeth while sleeping
__Gasps for air/ stops breathing (Sleep Apnea)

## Other Related Issues

__Neck or shoulder pain or tension
__Headaches or migraines
__Mouth open/mouth breathing during day
__Ear tubes previously
__Hyperactivity/Inattention
__TMJ Pain, clicking, or popping
__Strong gag reflex
__Tonsils or adenoids removed previously
__Reflux(medicated or not)
__Constipation

Pediatrician_____ Speech Therapist_____

Doctor's signature_____ Date_____