ALF EVALUATION

Name: _____ Age: _____ DOB: _____ Date: _____

Chief Complaint(s) : _____

1. Describe pregnancy: _____
2. MTHFR Testing? YES NO Explain: _____
3. Describe birth delivery: (normal, c-section, delayed, epidural, etc.) _____

   _____
4. Breast fed? YES NO
5. Breast fed for how long: _____
6. Painful or noisy breast feeding? YES NO Explain: _____
7. Visit with lactation consultant? YES NO Explain: _____
8. Did the baby experience any colic? YES NO Explain: _____
9. Supplemental bottle feeding? YES NO
10. At what age were solid foods introduced? _____
11. Crawling at what age? _____
12. Walking at what age? _____
13. Any trouble with fine motor skill development? (tying shoes, coordination, etc.) YES NO

    Explain: _____
14. Any childhood diseases? _____
15. Vaccinations? _____
16. History of any medications or antibiotics? _____
17. Any sucking habits? (Thumb, fingers, shirts, blankets, cheeks, pencils, etc.) _____
18. Sensory issues? (photo sensitive, noise, textures, etc.) YES NO Explain: _____

    _____

19. Messy eater, gulping while eating, fast/slow? YES NO Explain: _____

_____

20. Hiccups with regularity? YES NO Explain: _____

21. Picky eater? YES NO Explain: _____

22. Any gagging? (pills, foods, drinks, etc.) _____

23. Gas or bloating? _____

24. Any injuries, scars, or surgeries? Explain: _____

25. Any problems with tonsils and adenoids? (Removed, constantly swollen, trouble swallowing, etc.)

_____

26. Describe sleep? (how long, interrupted, difficulty to fall asleep or wake up, etc.) _____

_____

27. Bed wetting issues? _____

28. Sleep posture? (on back, side, stomach, etc.) _____

29. Teeth grinding? YES NO Explain: _____

30. Snoring? YES NO Explain: _____

31. Sleep apnea? YES NO Explain: _____

32. Headaches? YES NO Explain: _____

33. TMD pain or clicking of joints? YES NO Explain: _____

34. Ear aches? YES NO Explain: _____

35. History of ear infections or tubes? YES NO Explain: _____

36. Breathing? (mouth, nasal, congested, difficulty, wheezing, etc.) _____

_____

37. Allergies? YES NO Explain: _____

38. Any pets? YES NO Explain: _____

39. Posture assessment: (forward head posture, slouched, limp, etc.) _____

_____

40. Any behavior or social issues? (ADD, ADHD, Autism, Ausberger's, etc.) _____

_____

41. Any academic or learning issues? _____

42. Activities, sports, musical instruments? _____

43. Lip posture? OPEN CLOSED

44. Gummy smile? YES NO

45. Palate size and shape? _____

46. Diastema's present? YES NO Where: _____

47. Maxillary bone restriction? _____

48. Tongue position? (low tongue posture, anterior thrusts, lateral thrusts, etc.)

_____

_____

49. Maxillary frenum: NORMAL MILD MODERATE HEAVY

50. Lingual frenum: NORMAL MILD MODERATE HEAVY

51. Crowding of maxillary teeth? _____

52. Crowding of mandibular teeth? _____

53. Open bite? YES NO

Attitude: Patient :_____ Parent: _____

Patient Goals: _____

_____

Comments: