MYOGROWTH ACADEMY

PRE QUESTIONNAIRE FORM

PERSONAL INFORMATION

Date :

Full Name :

Date of birth : _____ / _____ / _____ **Age** : _____

Gender : ☐ Male ☐ Female ☐ Prefer not to say

Parent/ Guardian Name : _____

MEDICAL HISTORY

- Do you have any medical conditions? ☐ Yes ☐ No (If yes, please specify)

_____

- Are you currently taking any medications? ☐ Yes ☐ No (If yes, please specify)

_____

- Have you had any previous operations? ☐ Yes ☐ No (If yes, please specify)

_____

- Have you had any previous visits to the ENT and what was the outcome ? ☐ Yes ☐ No (If yes, please specify)

_____

- Do you suffer with any of the following?

☐ Frequent ear infections ☐ Frequent Throat Infections ☐ Other:

☐ Allergies ☐ Asthma ☐ Sinus, hay fever issues _____

FUNCTIONAL HISTORY

Birth: ☐ Natural ☐ C-Section ☐ Emergency C-Section

Any birth complications? _____

Breast-fed? Yes / No - if yes, ☐ Exclusive ☐ Combination

Exclusive breast feeding until what age? _____

Was breast feeding easy? ☐ Yes ☐ No Breastfeeding challenges: _____

Bottle-fed with formula / EBM / combination from _____ until _____

Introduced solids at age: _____

Parents noticed issues with speech / swallowing / eating? ☐ If yes, what? _____

Any history with the following parafunctional habits?

☐ Thumb / finger sucking from _____ until _____

☐ Pacificer from _____ until _____

SLEEP HISTORY

☐ Takes a long time to fall asleep - how long _____
☐ Snoring: _____
☐ Bruxism (teeth grinding): _____
☐ Mouth open: _____
☐ Restless: _____
☐ Bed-wetting: _____
☐ Gasping or breath holding: _____
☐ Waking up in the middle of the night: _____
☐ Waking up still tired in the morning: _____
☐ Concentration issues during the day: _____
☐ Easily distracted, fidgeting or struggles to sit still: _____
☐ Sleep Study? Yes / No - when? _____ Result _____

SPEECH HISTORY

☐ No issues detected previously by anyone
☐ Issues detected by: _____
☐ Pronounciations difficulties: S T L Th Ch Sh F Z
☐ Limited vocabulary
☐ Mumbling / Muffled sound
☐ Stutter / Stammer
☐ Management by speech pathologist? Y / N
Name of Pathologist: _____
Therapy from _____ until _____

NUTRITION

☐ Intolerances / Allergies: _____
☐ On a diet program: _____
☐ Dairy-free ☐ Sugar-free ☐ Gluten-free
☐ Refined sugars - days per week: _____
☐ Dairy: _____ Dairy-free _____
☐ Gluten - days per week: _____
☐ Nutritionist or Dietitian? _____
From _____ until _____
☐ Favourite food: _____