AEI **A**irway *focused* **L**ingual *posture* **F**acial *growth guidance*

EVALUATION

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

Chief Complaint(s) : _____

1. Describe pregnancy: _____
2. Describe birth delivery: (c-section, prolonged, epidural, induced, breach, forceps, bruising etc.) _____

   _____
3. Breast fed? how long? YES NO Explain: _____
4. Painful, noisy, problems latching with breast feeding? YES NO

   Explain: _____
5. History of frenectomy or diagnosed tongue tie? Explain: _____
6. Visit(s) with lactation consultant? YES NO Explain: _____
7. Did the baby experience any colic? YES NO Explain: _____
8. Any bottle feeding? YES NO Explain: _____
9. At what age were solid foods introduced? _____
10. Crawling at what age, describe crawl? _____
11. Walking at what age, describe? _____
12. Any trouble with fine or gross motor skill development? (tying shoes, coordination, etc.) YES NO

    Explain: _____
13. Any diseases or illnesses? _____
14. Any problems with skin rashes or eczema? _____
15. Vaccinations (normal, delayed schedule, none)? _____
16. Describe any reactions to the vaccinations? _____
17. History of any medications or antibiotics? _____
18. Any sucking habits? (fingers, nails, shirts, blankets, cheeks, pencils, etc.) _____
19. Sensory issues? (photo sensitive, noise, textures, tags, etc.) YES NO Explain: _____

20. Picky eater? YES NO Describe diet: _____

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

22. Describe any digestive problems? _____

23. Any scars, surgeries, falls or car accidents? Explain: _____

_____

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

_____

25. History of night terrors? _____

26. Bed wetting issues? _____

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

28. Teeth grinding? YES NO Explain: _____

29. Snoring? YES NO Explain: _____

30. Breath holding? YES NO Explain:_____

31. Headaches? YES NO Explain: _____

32. TMD pain, clicking, ringing of the ears? YES NO Explain: _____

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

34. History of chronic congestion or sinusitis? YES NO Explain: _____

35. Any problems with tonsils and adenoids?_____

36. History of Asthma and/or inhaler?_____

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

38. Mouth open at night during sleep? _____

39. Any allergies? YES NO Explain: _____

40. Any pets? YES NO Explain: _____

41. Any behavior or social issues? (Autism Spectrum, ADD, etc.) _____

_____

42. How are peer-peer interactions, describe: _____

43. Any academic or learning issues? _____

44. Speech issues? (lisp, speech therapy, etc.) _____

45. Activities, sports, musical instruments? _____

46. Any history of previous orthodontics? Explain: _____

47. Problems with cavities in the past? _____

CLINICAL ASSESSMENT (DONE BY DENTIST/STAFF)

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

49. Gummy smile? YES NO

50. Lip posture (lip seal, sucked in lower lip, etc)?

51. Palate size and shape? _____

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

53. Maxillary bone restriction? _____

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

55. Maxillary frenum: NORMAL MILD MODERATE HEAVY

56. Lingual frenum: NORMAL MILD MODERATE HEAVY

57. Crowding of maxillary or mandibular teeth? _____

58. Open bite? YES NO

59. Crossbites? YES NO Explain: _____

Attitude: Patient :_____ Parent: _____

Patient Goals: _____