Mouth Development Assessment

Patient's Name: _____ Date of Birth: _____

Today's Date: _____

Has the patient had any of the following:	Yes	No	Comments:
Acid Reflux			
Mouth Breathing			
Tongue Tie			
Frequent Bed Wetting			
Snoring			
Tonsils/ Adenoids Removed			
Speech Disorders			
Difficulty Eating or Swallowing			

History of or currently:	
Thumb or finger sucking	
Pacifier	
Nail biting	
Other non-nutritive sucking habits:	