HONOR HF FRANKLIN
MYOFUNCTIONAL & SPEECH CLINIC
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Date:_____

CONFIDENTIAL AND PRIVILEGED INFORMATION

IMPORTANT: Fill out this form as completely as possible and have copies of all pertinent medical, educational and psychological information sent to us. Feel free to explain your answers by writing in the margins and on the back of these sheets.

MYOFUNCTIONAL THERAPY CASE HISTORY (adult)

Patient's Name:_____ Sex:_____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ E-mail:_____

Date of Birth:_____ Age:_____

Reason for evaluation:_____

Complete the following if applicable:

Employer:_____ Bus. Address:_____

City/State:_____ Zip:_____

Spouse's Name:_____ Spouse's Employer:_____

Bus. Address:_____City/State:_____Zip_____

Name of person who referred you:_____

Address:_____ City/State:_____ Zip:_____

Name of Orthodontist:_____ Phone:_____

Address:_____ City/State:_____ Zip:_____

Name of General Dentist:_____ Phone:_____

Address:_____ City/State:_____ Zip:_____

Name of Physician:_____ Phone:_____

Address:_____ City/State:_____ Zip:_____

FAMILY

Person(s) responsible for this account:

Name:_____ Phone:_____

Address:_____ City/State:_____ Zip:_____

PRENATAL AND BIRTH HISTORY:

During this pregnancy, describe the mother's experience with any unusual illness, condition or accident, such as German Measles, false labor, RH incompatibility, etc.: _____

_____

_____

Length of Pregnancy:_____ Duration of Labor:_____

Birth Weight:_____ Condition at Birth:_____

Caesarean?_____ Breech?_____ Anesthetics?_____ Forceps?_____

Was the infant blue?_____ Jaundiced?_____ Other unusual conditions:_____

_____

MEDICAL

If the patient has had any of the following, indicate at what age and the degree of severity:

AGE/SEVERITY	AGE/SEVERITY
WHOOPING COUGH	EAR ACHES
MUMPS	RUNNING EARS
SCARLET FEVER	CHRONIC COLDS
MEASLES	HEAD INJURIES
CHICKEN POX	VENEREAL DISEASE
PNEUMONIA	ASTHMA
DIPTHERIA	ALLERGIES
INFLUENZA	ENCEPHALITIS
POLIO	HIGH FEVERS
HEADACHES	TYPHOID
SINUS	TONSILLITIS
MENINGITIS	TONSILLECTOMY
RICKETS	ADENOIDECTOMY
RHEUMATIC FEVER	MASTOIDECTOMY
PLEURISY	THYROID
TUBERCULOSIS	HEART TROUBLE
SMALL POX	ENLARGED GLANDS
CROUP	CONVULSIONS

Do you still have your tonsils and adenoids?_____

Has there been any previous speech, language and myofunctional (tongue thrust) therapy?_____

If so, where and by whom?_____

Are you on any medications at this time?_____

If so, please list:_____

_____

Describe any additional physical or medical problems, including past hospitalizations or surgeries):_____

_____

_____

DEVELOPMENT

When did you sit alone?_____

When did you walk alone?_____

When did you say your first words?_____

When did you combine words?_____

Do you prefer the right or left hand?_____

Bottle or breast fed?_____ If breast fed, for how long?_____

Was a bottle used for supplemental feeding?_____

Did you experience colic as a baby?_____

Did you refuse to accept the bottle as a baby?_____

Were there any feeding difficulties?_____

Were you easily weaned?_____ At what age?_____

Did you take solids easily?_____

PRESENT EATING HABITS

Are you a fast eater?_____ Or a slow eater?_____

Do you drink much liquid with your meals?_____

Do you chew your food with your mouth open?_____

Do you gulp your food or liquid?_____

Are you a noisy eater?_____

SUCKING HABITS

Have you ever sucked your thumb?_____ Finger?_____ Knuckle?_____

Lips?_____ Blanket?_____ Pacifier?_____ If so, has anything been attempted to stop the sucking habit?_____

What has been done? What success have you had?_____

NERVOUS DISEASES

Do you have any nervous diseases?_____

Do you suffer from epileptic seizures?_____

Do you have a tendency to be tense and/or nervous?_____

Have you had any type of counseling or psychotherapy?_____

OTHER CONDITIONS

Do you have any allergies?_____

Do you have any other physical problems which might have an effect on therapy?_____

_____

Do you experience any difficulty swallowing pills?_____

Are you a mouth breather?_____

Have you ever worn any type of orthodontic appliance?_____

If so, what type and for how long?_____

Please describe the problems for which you are seeking help. Also, give any other concerns you have which contribute to the difficulty. What have you been told about the cause of your problems? What has been done about your problems? Please include any questions you would like me to answer.

_____

_____

_____

_____

_____

_____

_____

_____

Signature of person completing form:_____

Relationship to patient:_____ Date:_____

HONOR FRANKLIN MYOFUNCTIONAL & SPEECH CLINIC
MYOFUNCTIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY
HONOR FRANKLIN, DIRECTOR
5438 ALPHA ROAD
DALLAS, TEXAS 75240

Telephone (972) 233-1312
Fax (972) 701-0322

AUTHORIZATION FOR RELEASE OF INFORMATION

DATE:_____

RE:_____, _____, _____
Last Name First Name Middle Initial

I, the undersigned, authorize Dr. Honor Franklin of the Honor Franklin Myofunctional & Speech Clinic, to acquire and/or release professional information from and to my physician and/or other professional personnel involved in the evaluation and management of requested services.

Signed:_____

_____
Relationship to Patient

I hereby authorize Dr. Honor Franklin of the Honor Franklin Myofunctional & Speech Clinic, exercising due discretion, for educational and scientific/professional purposes, and in the public interest, to make customary and constructive use of information, photographs, sound recordings, films and other records or materials pertaining to, and in consideration of, my enrollment, examination, instruction and scientific participation, or that of my minor child_____ for whom I am legally responsible, in the Franklin Speech, Language and Myofunctional Clinic.

Signed:_____

_____
Relationship to Patient