HONOR HF FRANKLIN
MYOFUNCTIONAL & SPEECH CLINIC
5438 ALPHA ROAD
DALLAS, TEXAS 75240
Telephone: (972) 233-1312
Fax: (972) 701-0322
honorfranklin@honorfranklin.com

Date:_____

CONFIDENTIAL AND PRIVILEGED INFORMATION

Person completing this form:_____

Relationship to the patient:_____

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 (child)

Patient's Name:_____ Sex:_____

Address:_____ City/State:_____ Zip:_____

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

Date of Birth:_____ Age:_____

Reason for evaluation:_____

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:_____

School:_____ Grade:_____

Principal:_____ Phone:_____

Address:_____ City/State:_____ Zip:_____

FAMILY:

Person(s) responsible for this account:

Name:_____ Phone:_____

Address:_____ City/State:_____ Zip:_____

Father's Full Name:_____

Date of Birth:_____ Age:_____ Marital Status:_____

Employer:_____Occupation:_____

Bus. Address:_____Bus.Phone:_____
City/State_____ Zip:_____

Mother's Full Name:_____

Date of Birth:_____ Age:_____ Marital Status:_____

Employer:_____Occupation:_____

Bus. Address:_____ Bus. Phone:_____
City/State:_____ Zip:_____

Other children in Family, Ages, Problems, if any:_____

_____

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

Does the patient still have his/her 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 the patient sit alone?_____

When did the patient walk alone?_____

When did the patient say first words?_____

When did the patient combine words?_____

Does the patient prefer the right or left hand?_____

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

Was a bottle used for supplemental feeding?_____

Did the patient as a baby experience colic?_____

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

Were there any feeding difficulties?_____

Was the patient easily weaned?_____ At what age?_____

Did the patient take solids easily?_____

PRESENT EATING HABITS

Is the patient a fast eater?_____ Or a slow eater?_____

Does the patient drink much liquid with his/her meals?_____

Does the patient chew his/her food with their mouth open?_____

Does the patient gulp his/her food or liquid?_____

Is the patient a noisy eater?_____

SUCKING HABITS

Does the patient suck his/her 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

Does the patient have any nervous diseases?_____

Does the patient suffer from epileptic seizures?_____

Does the patient have a tendency to be tense and/or nervous?_____

Have you had any type of counseling or psychotherapy?_____

OTHER CONDITIONS

Does the patient have any allergies?_____

Does the patient have any other physical problems which might have an effect on therapy?_____

_____

Does the patient experience any difficulty swallowing pills?_____

Is the patient a mouthbreather?_____

Has the patient ever worn any type of orthodontic appliance?_____

If so, what type and for how long?_____

Please describe the patient's 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 the patient's problems? What has been done about the patient's problems? Please include any questions you would like me to answer.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of person completing form:_____

Relationship to patient:_____ Date:_____

FRANKLIN SPEECH, LANGUAGE AND MYOFUNCTIONAL 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 Franklin Speech, Language and Myofunctional 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 Franklin Speech, Language and Myofunctional 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

PARENT PERMISSION FOR TESTING

Approval is hereby given for my child to receive the appraisal services offered by the Franklin Speech, Language and Myofunctional clinic. I understand that this evaluation will be done in the interest of my child's education development and will be administered by qualified personnel.

Signed:_____

_____
Relationship to Patient