Digit Sucking Registration

Child's Name **DOB**

Parent's Names

Email

Address

Contact Numbers

How did you hear about us?

Main Concern ☐ Tongue Thrust ☐ Finger ☐ Pacifier ☐ Other

When was your child's last dental exam?

Name of Dentist?

Orthodontist

Birth History

Was your child breastfed or bottle fed? ☐ Breastfed, how long? ☐ Bottle fed, how long?

Feeding history - difficulty with solids, etc?

Has your child seen a speech therapist? ☐ YES ☐ NO

Are you concerned about your child's speech? ☐ YES ☐ NO

Has your child ever seen an ENT/ALLERGIES? ☐ YES ☐ NO

Name of Specialist **Date**

Has your child had (tick)

☐ Tubes Placed ☐ Surgical Removal of Tonsils ☐ Surgical Removal of Adenoids/Turbinates

Has your child had a history of ☐ Colds ☐ Ear Infections ☐ Runny Nose ☐ Congestion

Does your child: Snore ☐ YES ☐ NO **Grind Their Teeth** ☐ YES ☐ NO

Make noise in their sleep ☐ YES ☐ NO **Breathe Loudly** ☐ DAY ☐ NIGHT

Does your child have a history of ☐ Bedwetting ☐ Eczema ☐ Nightmares/Night Terrors ☐ Reflux ☐ Sore Tummy ☐ Worms ☐ Gastro-Intestinal Upsets

Digit Sucking Registration

Does your child breathe through their nose or mouth when awake? ☐ Nose ☐ Mouth

Does your child breathe through their nose or mouth when asleep? ☐ Nose ☐ Mouth

Has your child ever had an injury to the face or mouth? ☐ YES ☐ NO

Details:

Sucking Habits

How many settings does the sucking occur?

☐ Tv ☐ Car ☐ Bed ☐ Bored ☐ Tired ☐ Upset ☐ Anxious ☐ When Not Busy Other ☐

Please write down other:

Any triggers (blanky, soft toy etc, when tired, tv etc)?

Does your child hair pull or twirl? ☐ YES ☐ NO

Home Life:

School Life:

Anxieties and Worries:

When did the habit start?

What do you do when it happens?

What sort of things have you done to try to stop the habit?