UCA SPEECH-LANGUAGE-HEARING CENTER
201 Donaghey Ave/UCA Box 4985 – Conway, AR 72035-0001 – 501-450-3176

Tongue Thrust Case History

Name: _____ Date: _____

Address: _____ Phone: _____

_____

DOB: _____ Age: _____ Sex: __ Male __ Female

Parent/Guardian:_____

Occupation: _____ Employer: _____

Referred by: _____

Summarize the problem: _____

_____

_____

_____

Describe briefly the child's health and/or any physical, speech, hearing, or emotional problems present: _____

_____

_____

_____

Does anyone on the paternal side of the family have any physical, speech, hearing or emotional problems? _____

_____

_____

Does anyone on the maternal side of the family have any physical, speech, hearing or emotional problems? _____

_____

_____

List brothers and sisters, their ages and any corresponding physical speech, hearing, or emotional problems.

Name	**Age**	**Comments**

Have you/your child had any allergies? ___ Yes ___ No If yes, please explain:

_____

_____

Does the following apply to you/your child:

Problem	**Yes**	**No**
Nail biting		
Thumb sucking		
Mouth breathing		
Other:		

Is there any abnormality in the following:

Problem	**Yes**	**No**
Tongue		
Throat		
Jaws		
Teeth		
Nasal Passages		
Palate		
Other:		

Please include any additional information that you feel will help us in understanding you/your child's problem: _________

_____

_____

_____

_____
Signature

_____
Relation to Client