

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

The UCA Speech Language Hearing Center shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.