Adult Tongue Tie Questionnaire

Patient's Name______________________________ Birthday_____________ Age______ Today's Date___________________

Medical Issues: ______________________________ Medications taking: ____

Allergies: ___________________________________ Previous clip or release of tongue/lip? _____________________(date)

1. Have you experienced any of the following issues? Please mark and elaborate as needed.

Speech

__Frustration with communication
__Difficult to understand
__Difficulty speaking fast
__Difficulty getting words out (groping for words)
__Trouble with sounds (which?)____________________
__Speech delay (when?)_____________________________
__Stuttering
__Speech harder to understand in long sentences
__Speech therapy (how long)______________________
__Mumbling or speaking softly

Sleep issues

__Wake easily or often
__Wet the bed
__Wake up tired and not refreshed
__Grind teeth while sleeping
__Sleep with mouth open
__Snore while sleeping (how often?)________________
__Gasp for air or stop breathing (sleep apnea)
__Wear C-PAP machine
__Wear sleep appliance (night-guard)
__Sleep in strange positions
__Kick and flail around at night

Feeding

__Frustration when eating
__Slow eater
__Graze on food throughout the day
__Packing food in cheeks like a chipmunk
__Picky eater / with textures (which?)________________
__Choking or gagging on food
__Won't try new foods
__Other: ____

Other Related Issues

__Neck or shoulder pain or tension
__TMJ pain, clicking or popping
__Headaches or migraines
__Strong gag reflex
__Mouth open/mouth breathing during the day
__Tonsils or adenoids removed previously
__Ear tubes previously
__Acid Reflux (medicated or not)
__Hyperactivity / Inattention
__Constipation
__Thumb sucking (previous or present)
__Problems breastfeeding when you were a baby

Anything else we need to know?

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If referred here, who referred you to us?

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For the office: ______________________