

Today's Date _____

Home Phone _____

Patient's Name _____ Nickname _____ Age _____

Birth Date _____ School _____ Grade _____

Patient's Address _____ City _____ State _____ Zip _____

Referred by: _____ For _____

Father's Name _____ Employed by _____ Phone _____

Mother's Name _____ Employed by _____ Phone _____

Physician's Name _____ Dentist's Name _____

Last physical examination _____ Dental examination _____

Are parents divorced? _____ If so, for how long? _____ Does the patient have brothers and sisters? _____ If so, what are their ages? _____ Did any of patient's brothers and sisters have a thumb/finger-sucking habit? _____ Is so, is their habit discontinued? _____

Does the patient suck a thumb _____ or finger? _____ Age the thumb/finger-sucking habit began? _____

Does the patient suck thumb/finger(s) on *either* hand? _____ Did the patient use a pacifier? _____ If so, until what age? _____ did the patient switch between sucking the pacifier or the thumb/finger? _____

Or did he/she suck the pacifier ONLY and begin sucking thumb/finger when the pacifier was taken away? _____ Does your child suck on his/her tongue _____ or lips? _____

In order to help your child eliminate the sucking habit it is very important to address ALL aspects of the behavior. Please check any of the following times that the sucking occurs:

When fatigued/tired _____ At bedtime/naptime _____ When stress/angry or mad _____ When excited _____ When bored _____ While watching TV _____ While riding in the car? _____ At school _____ At day-care facility _____ At church _____ When hungry _____ When in the presence of peers or others outside of immediate family _____ Other _____

Has your child received negative comments about his/her sucking activity from:

Parents _____ Brothers/Sisters _____ Relatives _____ Other children/peers _____ Teacher(s) _____ Dentist _____ Physician _____ Day-care provider(s) _____ Other _____

If the sucking activity *occurs in the classroom setting*, has the teacher ever expressed concern with regard to the sucking activity interfering with: classroom participation _____ Scholastic achievement _____ Your child's ability to focus on subject matter? _____ Verbal communication _____ Socialization with classmates _____ Manipulation of materials _____ Other _____

If your child does **NOT** suck the thumb/finger(s) in the classroom has the teacher ever commented that your child: Appeared to have difficulty sitting still _____ Was disruptive during classroom instruction _____ Displayed aggressive behavior _____ Chews on pencils _____ Clothing _____ Other _____

Does your child have a fingernail-biting habit? _____ If so, at what age did this habit begin? _____

Has your child ever had a sore/infected fingernail due to the thumb/finger-sucking habit? _____

Does your child have a special blanket or other object that he/she uses during the thumb/finger sucking activity? _____ If so, please explain _____

Does your child pull/twirl hair while thumb/finger sucking? _____ If so, has there been a problem with loss of hair? _____ Any other conjoined behavior while thumb/finger sucking? _____

Are you aware of any speech problems? _____ Has the patient had speech therapy? _____ If so, for how long? _____ If your child has been evaluated by a speech therapist or is receiving speech therapy, is the speech therapist aware that your child has a thumb/finger-sucking habit? _____

Have you been trying to get your child to discontinue the thumb/finger-sucking habit? _____ If so, please check any of the following methods that you have utilized:

Band-Aids _____ Liquids on thumb/fingers _____ Promises of prizes _____ Progress charts _____ Gentle reminders _____ Nagging _____ Punishment _____ Discipline _____ Other _____

Are you aware of any dental malocclusion (crooked teeth/bite problems) that may be a result of your child's thumb/finger-sucking habit? _____ If so, please explain. _____

Is your dentist aware of your child's sucking habit? _____ If so, what recommendation has he/she made with regard to the behavior? _____

Has your child ever had a dental appliance placed in his/her mouth to try to terminate the thumb/finger-sucking habit? _____ If so, was the appliance removable _____ or cemented _____ on to the teeth? How long did your child have the appliance? _____ Did your child stop the sucking habit while using the appliance? _____ If so, did the sucking resume after discontinuing the use of the appliance? _____ Did dental insurance provide a benefit for the appliance? _____

Has your child ever been to see an orthodontist? _____ If so, is the orthodontist aware of the sucking habit? _____ If so, what recommendation were made with regard to the behavior? _____ Has your child had any orthodontic treatment? _____ If so, for how long? _____

Is your child's physician aware of your child's sucking habit? _____ If so, what recommendation has he/she made with regard to the behavior? _____

PLEASE COMPLETE THE FOLLOWING REGARDING YOUR CHILD'S HEALTH HISTORY:

Ear infections _____ Has the patient had tubes placed in his/her ears? _____ Allergies? _____ Sinusitis _____ Chronic congestion _____ Tonsillitis _____ If so, how frequent? _____ Strep throat _____ If so, how frequent? _____ Tonsil removed _____ Adenoids removed _____ If so, when _____ Does your child snore when sleeping? _____ Is your child currently taking any medications? _____ For _____ Does your child have a history of neurological problems? _____ If so, please explain _____ Does your child have lips parted frequently? _____

ADDITIONAL COMMENTS: _____