



520 Montana Avenue Santa Monica CA 90403 / 310-739-9337 / lisakleinspeech@yahoo.com / www.lisakleinspeech.com

OBSERVATION FORM FOR PARENTS

PATIENT INFORMATION

Patient Name:
Date:
Person filling out questionnaire:
Relationship to Patient:

INSTRUCTIONS

Please observe your child over the next several days and answer the following questions. Do not make your child aware that you are observing them.

EATING AND DRINKING

Does your child have any allergies or food sensitivities? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what are they?
Does your child chew with their mouth/lips open? Yes <input type="checkbox"/> No <input type="checkbox"/>
Approximately how many chews for each mouthful?
Does your child seem to prefer to chew on one side of their mouth? Yes <input type="checkbox"/> No <input type="checkbox"/>
Which side?
What size bites does your child take of food? Large <input type="checkbox"/> Average <input type="checkbox"/> Small <input type="checkbox"/>
How does your child chew food? Rapidly <input type="checkbox"/> Moderately <input type="checkbox"/> Slowly <input type="checkbox"/>
Does food escape during chewing? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your child messy when eating an ice cream cone? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you hear sounds when your child eats? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe:
In what order does your child typically finish at the dinner table?: First <input type="checkbox"/> Last <input type="checkbox"/>



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Does your child seem to drink liquid excessively with dinner? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child need to wash down food with liquids? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child balloon their lips and cheeks when drinking? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child stick his/her tongue into a water bottle to drink? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have difficulty swallowing pills, now, or in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have excessive indigestion after he/she eats? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did your child ever have difficulty nursing, taking a bottle, or eating as an infant? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:

FOOD PREFERENCES

Is your child a picky eater? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do certain textures bother him/her? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe:
What is a typical breakfast for your child?
What is a typical lunch for your child?
What is a typical dinner for your child?
Please list the foods your child does NOT like:

SLEEPING

Does your child sleep with their mouth open? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child snore? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child grind their teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child wake up with a wet pillow from drooling? Yes <input type="checkbox"/> No <input type="checkbox"/>



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How many pillows does your child sleep with?
Does your child sleep on their: Back <input type="checkbox"/> Side <input type="checkbox"/> Stomach <input type="checkbox"/>
Does your child wake up: Rested <input type="checkbox"/> Tired <input type="checkbox"/>
Does your child have or had sleep apnea? Yes <input type="checkbox"/> No <input type="checkbox"/>

RESPIRATION

Has your child seen an ENT? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who?
Has your child had a tonsillectomy? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when: _____
Has your child had an adenoidectomy? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when: _____
Has your child had frenoplasty due to "tongue or lip tie"? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when: _____
When your child is watching TV, is their mouth open? Yes <input type="checkbox"/> No <input type="checkbox"/>
When your child is doing homework, is their mouth open? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you see your child licking their lips? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have frequent colds? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child need to blow their nose often? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have asthma? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what medication?
Does your child have respiratory allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what medication?

THUMB/FINGER SUCKING

Does your child suck their thumb? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child suck their fingers? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child suck a pacifier? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child bite his/her nails? Yes <input type="checkbox"/> No <input type="checkbox"/>



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TEETH

Has your child seen an Orthodontist? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who?																								
Is your child currently wearing braces? Yes <input type="checkbox"/> No <input type="checkbox"/>																								
If yes, for how long and when will he/she get them off?																								
If yes, briefly describe your child's teeth before braces:																								
If yes, has your child's orthodontist ever expressed difficulty in getting your teeth to move or stay properly? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:																								
If no, has your child worn braces before? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when: _____																								
If no, is your child going to be getting braces? Yes <input type="checkbox"/> No <input type="checkbox"/> When: _____																								
Is your child presently wearing, or has he/she worn, any of the following: <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 25%;">Headgear:</td> <td style="width: 10%;">Yes <input type="checkbox"/></td> <td style="width: 10%;">No <input type="checkbox"/></td> <td style="width: 55%;">If yes, when: _____</td> </tr> <tr> <td>Elastics:</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>If yes, when: _____</td> </tr> <tr> <td>Palatal Expander:</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>If yes, when: _____</td> </tr> <tr> <td>Retainers:</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>If yes, when: _____</td> </tr> <tr> <td>Positioner:</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>If yes, when: _____</td> </tr> <tr> <td>Thumb Reminder Device:</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>If yes, when: _____</td> </tr> </table>	Headgear:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, when: _____	Elastics:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, when: _____	Palatal Expander:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, when: _____	Retainers:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, when: _____	Positioner:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, when: _____	Thumb Reminder Device:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, when: _____
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Has your child had a frenectomy? Lingual Yes <input type="checkbox"/> No <input type="checkbox"/> Upper Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when: _____																								