LKS & ASSOCIATES
Speech and Occupational Therapy

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lksandassociates.com / www.lksandassociates.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 ▢ No ▢ If yes, what are they?
Does your child chew with their mouth/lips open? Yes ▢ No ▢
Approximately how many chews for each mouthful?
Does your child seem to prefer to chew on one side of their mouth? Yes ▢ No ▢ Which side?
What size bites does your child take of food? Large ▢ Average ▢ Small ▢
How does your child chew food? Rapidly ▢ Moderately ▢ Slowly ▢
Does food escape during chewing? Yes ▢ No ▢
Is your child messy when eating an ice cream cone? Yes ▢ No ▢
Do you hear sounds when your child eats? Yes ▢ No ▢ If yes, please describe:

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In what order does your child typically finish at the dinner table?: First ▢ Last ▢
Does your child seem to drink liquid excessively with dinner? Yes ▢ No ▢
Does your child need to wash down food with liquids? Yes ▢ No ▢
Does your child balloon their lips and cheeks when drinking? Yes ▢ No ▢
Does your child stick his/her tongue into a water bottle to drink? Yes ▢ No ▢
Does you child have difficulty swallowing pills, now, or in the past? Yes ▢ No ▢
Does your child have excessive indigestion after he/she eats? Yes ▢ No ▢
Did your child ever have difficulty nursing, taking a bottle, or eating as an infant? Yes ▢ No ▢ If yes, please explain:

FOOD PREFERENCES

Is your child a picky eater? Yes ▢ No ▢
Do certain textures bother him/her? Yes ▢ No ▢ 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 ▢ No ▢
Does your child snore? Yes ▢ No ▢

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Does your child grind their teeth? Yes ▢ No ▢
Does your child wake up with a wet pillow from drooling? Yes ▢ No ▢
How many pillows does your child sleep with?
Does your child sleep on their: Back ▢ Side ▢ Stomach ▢
Does your child wake up: Rested ▢ Tired ▢
Does your child have or had sleep apnea? Yes ▢ No ▢

RESPIRATION

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

THUMB/FINGER SUCKING

Does your child suck their thumb? Yes ▢ No ▢

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Does your child suck their fingers? Yes ▢ No ▢
Does your child suck a pacifier? Yes ▢ No ▢
Does your child bite his/her nails? Yes ▢ No ▢

TEETH

Has your child seen an Orthodontist? Yes ▢ No ▢ If yes, who?
Is your child currently wearing braces? Yes ▢ No ▢
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 ▢ No ▢ If yes, please explain:
If no, has your child worn braces before? Yes ▢ No ▢ If yes, when:_____
If no, is your child going to be getting braces? Yes ▢ No ▢ When:_____
Is your child presently wearing, or has he/she worn, any of the following: Headgear: Yes ▢ No ▢ If yes, when:_____ Elastics: Yes ▢ No ▢ If yes, when:_____ Palatal Expander: Yes ▢ No ▢ If yes, when:_____ Retainers: Yes ▢ No ▢ If yes, when:_____ Positioner: Yes ▢ No ▢ If yes, when:_____ Thumb Reminder Device: Yes ▢ No ▢ If yes, when:_____

Has your child had a frenectomy? Lingual Yes ▢ No ▢ Upper Yes ▢ No ▢ If yes, when:_____