MOUNTAINS
TMJ & DENTAL
SLEEP MEDICINE

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Paediatric Orthodontic Screening

Patient Name (Print) _____ **Date:** ____/____/_____

Section 1: First Impressions

Please tick one yes or no response for each question.

	No	Yes
Does the child regularly mouth breathe?	❑	❑
Are the front teeth crooked?	❑	❑
Do the upper front teeth appear to protrude?	❑	❑

Section 2: Subjective TMJ & Muscle Evaluation

Please tick one yes or no response for each question.

	No	Yes
Does the child grind their teeth in their sleep?	❑	❑
Does the child wake up at night or in the mornings with headaches?	❑	❑
Does the child snore?	❑	❑
Does the child have enlarged tonsils?	❑	❑
Does the child such their thumb or fingers?	❑	❑
Does the child use a dummy or pacifier?	❑	❑
Are there cross-bites in anterior or posterior teeth?	❑	❑
Anterior ❑ Posterior ❑		
Does the upper dental arch look narrow?	❑	❑
Does the child have nasal airway problems?	❑	❑
Does the child have allergies?	❑	❑
Does the child have difficulty closing their lips together normally and relaxed?	❑	❑
Is there a tongue-tie?.....	❑	❑
Does the child have any speech impediment?	❑	❑

Section 3: Prior Orthodontic Diagnosis

Please fill in the blanks, and tick one yes or no response for each question

	No	Yes
Has orthodontic treatment previously been recommended?	❑	❑
If Yes: When was it recommended? (Approx mo/yr) _____		
Did you see an Orthodontist for a consultation?	❑	❑
Are you seeking a second opinion?	❑	❑