Orthodontic Evaluation

Has your child (sibling/family member) had previous Orthodontic treatment?	Yes	No
Has either parent had Orthodontic Treatment?	Yes	No
Has your child had any injuries to the face, mouth or teeth? If yes, explain: ______________________	Yes	No
Has your child complained of pain or tenderness in his/her jaw joint (TMJ/TMD)?	Yes	No
Clenching/Grinding teeth	Yes	No
Mouth Breather/ Snoring	Yes	No
Thumb/Finger sucking	Yes	No
Tongue Thrust	Yes	No
Speech Problems	Yes	No