MOUNTAIN KIDS
PEDIATRIC DENTISTRY

Child Follow-Up Sheet

Patient's Name: _____ Date of Birth: _____

Today's Date: _____ Date of Procedure: _____ Days Since Procedure: _____

Has your child experienced improvement or changes in any of the following issues?

INSTRUCTIONS: Please mark any previous issues that saw improvement. Anything that worsened, please write below.

Speech

___ Easier to communicate
___ Easier to understand by parents
___ Easier to understand by outsiders
___ Easier to speak fast or long sentences
___ Easier to get words out (not groping for words)
___ Easier with sounds (which?) _____
_____
___ New words _____
_____
___ Talking more (or more babbling)
___ Less stuttering
___ Less mumbling or speaking softly
___ Less "baby talk"

Anything worsened?: _____
_____
_____

Additional Comments: _____
_____
_____
_____
_____
_____
_____
_____

Feeding

___ Less frustration when eating
___ Easier to eat/swallow solid foods
___ Eating faster
___ Eating more food
___ Finishing meals better/less grazing on foods
___ Trying new foods
___ Less packing food in cheeks (like a chipmunk)
___ Less picky with textures (which?)
_____
___ Less choking or gagging on food
___ Less spiting out food
___ Other:

Anything worsened?: _____
_____
_____

Additional Comments: _____
_____
_____
_____
_____
_____
_____
_____

Sleep Issues

___ Less sleeping in strange positions
___ Less moving around at night (less restless)
___ Sleeping deeper and waking less often
___ Less wetting the bed
___ Wakes up less tired and more refreshed
___ Less grinding teeth while sleeping
___ Less sleeping with mouth open
___ Less snoring while sleeping
___ Less gasping for air or stopping breathing

Anything worsened?: _____
_____
_____

Other Related Issues

___ Less neck or shoulder pain or tension
___ Less TMJ pain, clicking, or popping
___ Less headaches or migraines
___ Less strong gag reflex
___ Less mouth open/mouth breathing during the day
___ Less reflux
___ Better attention span
___ Less hyperactivity issues
___ Less constipation
___ Easier to brush top teeth (after lip-tie release)
___ More cosmetic smile (after lip-tie release)

How much change did you see from the release?

INSTRUCTIONS: Circle the best answer.

Speech

Significantly Better	Somewhat Better	No Change	Somewhat Worse	Significantly Worse	No Prior Issues

Feeding

Significantly Better	Somewhat Better	No Change	Somewhat Worse	Significantly Worse	No Prior Issues

Sleep

Significantly Better	Somewhat Better	No Change	Somewhat Worse	Significantly Worse	No Prior Issues

Looking back, if you "had to do it all over again," would you?

Yes	Maybe (Probably Yes)	Unsure	Don't Think So	Never

If you have any questions or concerns, please give us a call any time at 970.224.3600
We're here to support you 100% of the way through your child's recovery.