MOUNTAIN KIDS
TONGUE & LIP TIE CENTER

CHILD

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.