Patients Name: ____

DOB: _____/________/_______

Parents Name: ____

Phone: ____

Email: ____

Date: ____

Referred by: ____

Please address the following Myofunctional concerns:

Tongue thrust swallowing pattern

Open mouth rest posture/ Low tongue posture

Mouth breathing

Tongue-tie/restricted lingual frenum

Thumb/finger sucking habit

TMJ disorder/pain/discomfort

Adenoid/Tonsil hypertrophy

Sleep apnea/sleep disorder breathing/snoring

Headaches/clenching/grinding

Orthodontic relapse

Other concerns noted: ____

Orofacial Myofunctional Therapist Parisa@functionalmouth.com (760)310-4069

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