Breathe Better
Myofunctional Therapy

Annie Denning, BS, RDH Orofacial Myologist

Date _____/_____/_____

Patient Name _____

Date of Birth _____/_____/_____

Parent Name _____

Phone _____

Email _____

Referred By _____

Comments _____

Please evaluate the following:

- ☐ Mouth breathing/Open mouth rest posture
- ☐ Tongue thrust swallowing pattern
- ☐ Tongue-tie/restricted lingual frenum
- ☐ Labial tie/restricted maxillary frenum
- ☐ Post frenectomy care
- ☐ Digit sucking/other oral habits

Other concerns noted:

- ☐ TMJ disorder/pain/discomfort
- ☐ Speech problems
- ☐ Adenoid/Tonsil hypertrophy
- ☐ Sleep apnea/disordered breathing/snoring
- ☐ Headaches/clenching/grinding
- ☐ Other: _____

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