Breathe Better
Myofunctional Therapy
Annie Denning, BS, RDH — Orofacial Myologist

Date ______/______/______

Patient Name ______________________________

Date of Birth ______/______/______

Parent Name ______________________________

Phone ______________________________

Email ______________________________

Doctor Signature ______________________________

Please evaluate and treat:

- ☐ Mouth breathing (ICD-10-CM R06.5)
- ☐ Dysfunctional swallow (ICD-10-CM M26.50)
- ☐ Tongue-tie/restricted lingual frenum (ICD-10-CM Q38.1)
- ☐ Tooth crowding (ICD-10-CM M26.31)
- ☐ Digit sucking/oral habits (ICD-10-CM F98.8)
- ☐ Labial tie/restricted maxillary frenum

Other concerns noted:

- ☐ TMJ disorder/pain/discomfort (ICD-10-CM 68.84)
- ☐ Sleep apnea/snoring (ICD-10-CM R06.83)
- ☐ Clenching/grinding (ICD-10-CM F45.8)
- ☐ Sleep related bruxism ((ICD-10-CM G47.63)
- ☐ Headaches (ICD-10-CM R51.9)

Comments ____

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