Breathing Essentials
Myofunctional Therapy, LLC

Today's Date:_____

Client Name:_____ Age:_____

Contact Name:_____

Contact Phone Number:_____

Contact Email Address:_____

Referred by:_____

Referring Office Phone Number: _____

Please Evaluate:

- [ ] Mouth Breathing
- [ ] Open Mouth Posture
- [ ] Thumb/Finger Sucking Habit
- [ ] Tongue Thrust Swallow
- [ ] TMD Pain/Discomfort
- [ ] Restricted Labial Frenum/Frena
- [ ] Tongue Tie/Restricted Lingual Frenum

Other Noted Concerns:

- [ ] Adenoids/Tonsils Hypertrophy
- [ ] Allergies
- [ ] Speech
- [ ] Headaches
- [ ] Clenching/Grinding
- [ ] Sleep Disordered Breathing
  - Sleep Apena
  - Snoring

Additional Comments:

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