Referral Form

Patient's Name: ____Age:__________________

Parent/ Guardian's Names:____

Date of Birth: ____

Phone Number:____

Email Address:____

Referred By:____

`Please ***CIRCLE*** Myofunctional Concerns:

Mouth Breathing   Open Mouth Posture   Low Tongue Posture   Tongue Thrust

Oral Habit

Please ***CIRCLE*** Myofunctional Symptoms:

Tongue Tie   Open Bite   Narrow Palate   History of Oral Habit   Large Tonsils

Snoring   Daytime Sleepiness   Ortho relapse   Teeth Grinding/Clenching

Headaches   Fascial Pain/Tension

Other:____

Myo Matters Team

myomattersqc@gmail.com   www.myomatters.com

(563)-345-0044   141 E. 46th St Davenport, IA 52806