Patient's Name: _____Age:_____

Parents Names:_____

Referred By:_____

Myofunctional Concern:

Mouth Breathing Open Mouth Posture Low Tongue Posture Tongue Thrust Oral Habit

Myofunctional Symptom:

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

Daytime Sleepiness Ortho relapse Teeth Grinding/Clenching Headaches

Facial Pain/Tension Other:_____

Paula R Anderson RDH QOM

myomattersqc@gmail.com www.myomatters.com

(563)-355-2010 141 E. 46th St Davenport, IA 52806