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NAME _____

DATE _____

AGE _____

REFERRED BY _____

PHONE _____

REASON FOR MYOFUNCTIONAL REFERRAL

- MOUTH BREATHING
- TONGUE/LIP TIE
- SLEEP ISSUES
- SNORING
- LOW TONGUE POSTURE
- TMJ PAIN
- HABIT ELIMINATION
(NAIL BITING, THUMB SUCKING, ETC)
- CLENCHING/GRINDING
- HEAD/NECK/BACK PAIN
- MALOCCLUSION
- DENTAL CROWDING
- TONGUE THRUST
- OTHER:

