Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Office:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Patient(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for evaluation of orofacial myofunctional disorders, swallowing habits, sucking habits, or other dysfunctions.

 Patient DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Minor, Parent/Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please evaluate:

\_\_\_\_ Parafunctional habit: Thumb sucking \_\_\_\_ Finger\_\_\_\_ Lip\_\_\_\_ Pacifier\_\_\_\_ Other\_\_\_\_

\_\_\_\_ Tethered Oral Tissues (TOTs) Lingual\_\_\_\_\_\_ Max/Mand labial\_\_\_\_\_\_\_

 Max Buc\_\_\_\_\_ Mand Buc\_\_\_\_\_

\_\_\_\_ Tongue Thrust: Anterior\_\_\_\_\_ Bilateral\_\_\_\_\_ Unilateral\_\_\_\_\_\_\_\_

\_\_\_\_ TMJ Pain/Dysfunction

\_\_\_\_ Open Mouth Posture/Low resting tongue

\_\_\_\_ Mouth Breather Allergies: Yes\_\_\_\_\_ No\_\_\_\_\_\_

\_\_\_\_ Speech Disorders

\_\_\_\_ Sleep issues Restlessness\_\_\_\_\_\_\_ Bed wetting\_\_\_\_\_\_ Grinding/clenching\_\_\_\_\_\_\_

 Snoring\_\_\_\_\_\_

\_\_\_\_ Orthodontic relapse/open anterior bite

\_\_\_\_ Frequent Migraines/headaches/neck/back pain

\_\_\_\_ Anxiety/ADHD/Depression

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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