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 www.MyofunctionalPartners.com
 424-835-2759



Angie Bimat & Sarah Johnson
 Orofacial Myofunctional Therapists
 Certified in Buteyko Breathing Method

Patient: _____ Phone: _____ Email: _____

Referred by: _____ Phone: _____ Email: _____

Which conditions do you observe?

<input type="checkbox"/> MOUTH BREATHING VS. NASAL BREATHING	<input type="checkbox"/> LOW TONGUE REST POSTURE	<input type="checkbox"/> OPEN MOUTH POSTURE
<input type="checkbox"/> SNORING	<input type="checkbox"/> TONGUE THRUST- ANTERIOR	<input type="checkbox"/> TONGUE THRUST- POSTERIOR
<input type="checkbox"/> MALOCCLUSIONS	<input type="checkbox"/> CAVITIES AND GUM DISEASE	<input type="checkbox"/> SALIVA QUANTITY/QUALITY CONCERNS
<input type="checkbox"/> TONGUE TIE	<input type="checkbox"/> LIP TIE	<input type="checkbox"/> SMALL MAXILLA
<input type="checkbox"/> HIGH OR NARROW PALATE	<input type="checkbox"/> TONGUE SCALLOPING	<input type="checkbox"/> ATYPICAL SWALLOWING
<input type="checkbox"/> CRANIOFACIAL DYSFUNCTIONS	<input type="checkbox"/> HABITS	<input type="checkbox"/> CHEWING DISORDERS
<input type="checkbox"/> ALLERGIC SHINERS/VENOUS POOLING	<input type="checkbox"/> FACIAL MUSCLE DYSFUNCTION	<input type="checkbox"/> EUSTACHIAN TUBE DYSFUNCTION
<input type="checkbox"/> HYPERTONIC/HYPOTONIC MASSETERS	<input type="checkbox"/> AESTHETIC CHANGES	<input type="checkbox"/> MACROGLOSSIA
<input type="checkbox"/> SPEECH MISARTICULATIONS (LISPS)	<input type="checkbox"/> ABNORMAL BREATHING	<input type="checkbox"/> TONSILS/ADENOIDS ENLARGED
<input type="checkbox"/> ABNORMAL BREATHING	<input type="checkbox"/> TMJD	<input type="checkbox"/> TINNITUS
<input type="checkbox"/> SLEEP DISORDERS/SLEEP APNEA/UARS	<input type="checkbox"/> BRUXISM/CLENCHING	<input type="checkbox"/> FORWARD HEAD POSTURE

Notes: _____

Other Dental/Health Providers this patient is seeing for related issues:

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