FACIAL Physique | Orofacial Myofunctional Therapy

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Patient Information

NAME: ____________________

AGE: ____________________

PHONE: ____________________

EMAIL: ____________________

Orofacial Dysfunction

- ◯ Tongue Tie
- ◯ Tongue Thrust
- ◯ Low Tongue Tone
- ◯ Orthodontic Relapse
- ◯ Thumb/Finger Sucking
- ◯ Mouth Breathing
- ◯ Clencing/Grinding
- ◯ TMJ/TMD
- ◯ Sleep Apnea/UARS
- ◯ Snoring
- ◯ Other: ____________________

Referring Office

DOCTOR: ____________________

PHONE: ____________________

EMAIL: ____________________