Smile
MYO THERAPY

Date:_____

Patient Name:_____ Birthdate:_____

Minors only - Parent(s) Name:_____

Phone Number: _____

Referred by: _____

Referred for:

__Tongue Thrust
__Tongue and/or Lip Tie
__Low Tongue
__Habit Elimination
__Orthodontic Relapse
__Bite/Occlusion
__Jaw Pain/Dysfunction
__Other:

__Mouth Breathing
__Open Mouth Posture
__Allergies/Congestion
__Clenching/Grinding
__Snoring
__Sleep Quality
__Headaches

Additional Comments:

641-590-5054 (call or text)
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www.smilemyotherapy.com