NORTH SOUND
MYOFUNCTIONAL THERAPY

ANN O'CONNOR, RDH BAS

Edmonds, WA
(206) 406-6065
ann@northsoundomt.com

Patient Name _____

D.O.B. _____/_____/_____

Parent Name _____

Phone _____

Email _____

Please Evaluate the Following

- O Tongue thrust swallowing pattern
- O Open mouth rest posture
- O Mouth breathing
- O Tongue tie/restricted lingual frenum
- O Pre/post frenectomy care
- O Thumb/finger sucking habit

Concerns Noted

- O TMJ disorder/pain/discomfort
- O Speech problems
- O Adenoid/tonsil hypertrophy
- O Sleep apnea/sleep disordered breathing/snoring
- O Headaches/clenching/grinding
- O Other _____

Referring Office

Doctor _____

Phone _____

Email _____