Simply Myo
Myofunctional Therapy

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Patient Information

Name: _____

Age: _____

Phone: _____

Email: _____

Area of Concern

- ☐ Tongue Tie
- ☐ Tongue Thrust
- ☐ Low Tongue Tone
- ☐ Mouth Breathing
- ☐ Orthodontic Relapse
- ☐ Clenching/Grinding
- ☐ TMJ/TMD
- ☐ Sleep Apnea/UARS
- ☐ Snoring
- ☐ Other: _____

_____

Referring Office

Doctor: _____

Phone: _____

Email: _____