Face Fitness OMT

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Patient Name: ____ **Patient DOB:** ____

Patient Phone #: __________________ **Patient Email:** ____

Referring Doctor: ____**Phone:** ____

Email: ____

Reason for Referral: ____

DIAGNOSIS:

____ Anklyoglossia
____ Dentofacial Functional Abnormality
____ Oral Dysphagia
____ Feeding Difficulties
____ Speech Disturbances
____ Sleep related Bruxism, Grinding
____ Mouth Breathing,
____ Tongue Thrust, Thumb/ Finger Habit
____ Bitting: cheek or lip
____ TMJ Dysfunction
____ Facial Muscle Spasms
____ Headache or facial pain
____ Oral Incompetence due to Short Upper & Lower Labial Frenulum
____ Abnomalies of dental arch, Anterior Open Bite
____ Abnomalies of dental arch, Posterior Open Bite
____ Abnomalies of dental arch, Excessive Horizontal overjet
____ Abnomalies of dental arch, Crossbite
____ Abnomalies of dental arch, Inadequate interarch distance

For Evaluation and Management of Speech, Swallow, & Oral Motor Treatment Including:

_____ Exam Evaluation
_____ Treatment Exercises
_____ Oral Habit Intervention
_____ Myofacial Release Treatment
_____ Myofacial Release Treatment
_____ Treatment, Functional Performance
_____ Dysphagia Treatment
_____ Speech Treatment

Signature____Date___________________________