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**How do I know if I have a Myofunctional Disorder?**

Please circle all that apply if more than one option

**Top of Form**

1. Do you have an open mouth at rest posture or mouth breathe?  YES/NO

2. Does your tongue rest against your teeth?  YES/NO

3. Have your teeth moved after orthodontic treatment? YES/NO/No ortho

4. Do you have headaches often? YES/NO

5. Does your jaw or neck hurt often?  YES/NO

6. Do you chew your food with your mouth open? YES/NO

7. Are you a stomach or side sleeper?  YES/NO – circle which one

8. Do you have oral habits such as nail biting, pen chewing, lip licking or biting, or thumb sucking?  YES/NO – circle all that apply

9. Do you slouch or have a forward head posture?  YES/NO

10. Do you have a lisp when saying “S” sounds? YES/NO

11. Do you feel that your tongue comes forward when you swallow?  YES/NO

12. Do you drool or have bloating or stomach distress after eating?  YES/NO

13. Do you have trouble falling asleep?  YES/NO

14. Are you tired in the morning?  YES/NO

15. Do you snore or have sleep apnea? YES/NO

16. Do you wake up repeatedly at night?  YES/NO

Bottom of Form