Tacoma MyoTherapy

Patient Referral Form

Patient Name____

Date of Birth____________________ Phone: ____________________________

Parent/Guardian: ____

Email: ____

Referring Provider: ____

Myofunctional Concerns Reported:

- ☐ Snoring
- ☐ Acid Reflux
- ☐ Shoulder / Neck Pain
- ☐ Headaches / Migraines
- ☐ Clenching / Grinding
- ☐ TMD / Jaw Pain
- ☐ Orthodontic Relapse
- ☐ Visible Mouthbreathing
- ☐ Chronic Fatigue
- ☐ Dry Mouth / Bad breath
- ☐ Oral Habits / Thumbsucking
- ☐ Other: ______________________

Current Treatment Plan:

- ☐ Orthodontic Treatment
- ☐ Tonsil/Adenoids Evaluation
- ☐ Tongue Tie Release
- ☐ Mouth Appliance
- ☐ Other: ____

Please call or email to set up your initial evaluation

253-572-6670

Info@TacomaMyo.com

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