PHOENIX MYO

RISE + RESTORE + BREATHE

PHOENIX MYO

Call/Text 602-899-2331
www.phxmyo.com
info@phxmyo.com

Referring Provider: Date:

Referring Provider's Email: Phone:

Client's Name: DOB:

Parent/Guardian (if a minor): Phone:

Reason for Referral:

- ☐ Mouth Breathing
- ☐ Teeth Shifting
- ☐ Jaw Pain & Dysfunction
- ☐ Headaches/Migraines
- ☐ Anxiety/Depression
- ☐ Chronic Fatigue
- ☐ Tongue Thrust
- ☐ Tongue/Lip Tie
- ☐ Allergies/Congestion
- ☐ ADHD
- ☐ Open Bite/Malocclusion
- ☐ Speech Issues/Articulation
- ☐ Low Tongue Rest Posture
- ☐ Snoring/Sleep Apnea
- ☐ Head/Neck Tension

Additional Information: _____

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SCAN ME

Amy Donahoo, BSDH, OMT

Email completed form to info@phxmyo.com