



CALGARY MYOLOGY

MYOFUNCTIONAL THERAPY

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Amy Pester, BHSc RDH OMT
Myofunctional Therapist

Patient Information

Patient Name: _____

Patient Date of Birth: _____

Phone Number: _____ Date: _____

Email: _____

Referred By: _____ Phone: _____

Please Evaluate for the Following:

- | | |
|--|---|
| ☐ Tongue Thrust Swallow Pattern | ☐ Orthodontic Relapse |
| ☐ Tongue Tie | ☐ Snoring/Sleep Apnea |
| ☐ Severe Gag Reflex | ☐ Clenching/Grinding |
| ☐ Mouth Breathing | ☐ Thumb/Finger Sucking Habit |
| ☐ TMD Pain/Chronic Facial Pain | ☐ Low Tongue Tone/Lisp |
| ☐ Other: _____ | |

Comments

To Schedule a No-Charge Consultation
Please Call or Email Today

In Person or Virtual Consultation Options are Available
www.calgarymyology.com • info@calgarymyology.com