

BREATHWORKS™

Virtual - Lake Oswego - Portland - Camas - Eugene - Bend

Phone/Fax: 971-346-0355 www.breatheworks.com

Referral Date: _____

Patient Name: _____ Date of Birth: _____

Email: _____ Phone: _____

Tx Plan: _____

Other:

Referring Provider: _____

Please evaluate for:

- | | |
|---|--|
| <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Voice |
| <input type="checkbox"/> Tongue dysfunction | <input type="checkbox"/> Strong gag reflex |
| <input type="checkbox"/> Ankyloglossia | <input type="checkbox"/> Malocclusion |
| <input type="checkbox"/> TMJ/TMD | <input type="checkbox"/> Picky eating |
| <input type="checkbox"/> Attention/ADHD | <input type="checkbox"/> Allergies/Asthma |
| <input type="checkbox"/> Body posture | <input type="checkbox"/> Sleep dysfunction |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Digestion issues |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Gross/Fine motor |
| <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Noxious oral habits |
| <input type="checkbox"/> Swallowing | <input type="checkbox"/> Other _____ |

Breathe better Sleep better Talk better Eat better Feel better