INTAKEQ4U - NEW PATIENT NOTES (MYO)

1. Provider _____ Date _____ Start Time _____ End Time _____

2. Patient Name

_____

Date of Birth

_____

Referring Party

_____

Chief Complaint

_____

Appointment Location

_____

3. **Current Diagnosis**

4. **Case History**

_____

_____

_____

_____

ORAL REST POSTURE ASSESSMENTS

Oral rest posture is the positioning of the tongue, lips, and jaw when they are not being used for other oral functions, such as eating and speaking. There are many benefits to good oral rest posture, including support for speech and deglutition, long-term stability of orthodontic results, and the prevention or reduction of TMJ pain and dysfunction.

Good oral rest posture involves the tongue resting in a palatal position with the lips closed and 2-4mm of freeway space between the upper and lower teeth.

5. _____

Resting Position of the Lips

☐ Lips closed at rest ☐ Lips slightly parted at rest ☐ Lips fully opened at rest

Estimate Percentage of Incisor Show

_____

Resting Position of the Tongue

- ☐ Full tongue resting on the palate, with the tip of the tongue on the incisive papilla ("the spot")
- ☐ Tongue tip resting on the incisive papilla ("the spot")
- ☐ Tongue tip resting low and forward (against the upper teeth)
- ☐ Tongue tip resting low and forward (between teeth)
- ☐ Tongue tip resting low and forward (against lower front teeth) ☐ Tongue "floating" ☐ Unable to assess

Millimeters of Freeway Space

_____

Notes

_____

_____

BODY POSTURE AND BREATHING ASSESSMENTS

Neutral, balanced body posture promotes comfortable nasal breathing and good oral functions of speaking, mastication, and swallowing.

6. **Static Posture Photos**

7. **Static Posture Observations Purpose: Poor body posture can be associated with low tongue rest posture, mouth breathing, and dysfunctional deglutition. It has also been associated with TMJ dysfunction. Reference Value: A neutral, balanced posture is ideal.**

☐ Neutral, balanced ☐ Lordosis ☐ Kyphosis
☐ Flat Back ☐ Sway Back ☐ Scoliosis
☐ Unable to assess

8. **Occiput-to-Wall Test Purpose: A test for thoracic kyphosis and forward head posture. Reference Value: A value of greater than 2 cm is considered abnormal.**

_____

_____

_____

_____

9. **Beighton Scale/Hypermobility Assessment Purpose: Generalized joint hypermobility has been considered a predisposing factor for the development of temporomandibular disorder (TMD). Reference Value: Most providers will consider 4/9 generalized hypermobility.**

☐ Can hyperextend knees >10° (1 for each knee) _____
☐ Can hyperextend elbows >10° (1 for each elbow) _____
☐ Can extend 5th finger (pinky) >90° (1 for each hand) _____
☐ Can touch thumb to forearm (1 for each hand) _____
☐ Can touch hands flat on floor with straight knees (1 pt) _____
☐ Not assessed _____

10. **Brugger Test Purpose: To determine if an unlevel O-A joint and accompanying suboccipital**

spasm can be the result of poor head and neck positioning or misalignment elsewhere in the body. Reference Value: If the spasm decreases when the client sits, this suggests that asymmetry in the lower body is forcing O-A joint compensation. If the spasm persists when sitting, this suggests that O-A joint needs to be addressed.

- ○ Spasm decreases upon sitting
- ○ Spasm remains upon sitting
- ○ Not assessed

11. Breathing Pattern Assessment Purpose: These are signs of signs of dysfunctional breathing patterns. In contrast, slower, deeper, and more diaphragmatic breathing can stimulate the vagus nerve and activate the parasympathetic ("rest and digest") nervous system. Reference Value: None of the above.

- ☐ Tendency toward shallow, chest breathing
- ☐ Audible/noisy breathing
- ☐ Nostril flaring
- ☐ Rapid breathing rate (average is 20-30 breaths per minute for a child 1-5 years of age and 12-20 breaths per minute for adults and children 6 years of age and older.)
- ☐ None of the above
- ☐ Not assessed

12. Subjective Nasal Breathing Difficulty (On a scale of 0-10, with 10 being the worst) Purpose: If a patient does not feel like they can comfortable breathing through their nose, they will likely breathe through their mouth. Mouth breathing lengthens and narrows the upper airway, making it more vulnerable to collapse during sleep with inspiratory negative pressure. Nasal airway patency can be influenced by structural issues and allergies. In patients who feel uncomfortable breathing through their nose, and ENT and/or allergist evaluation may be warranted. Also, nasal clearing, a nasal hygiene routine, and breathing exercises may be of benefit. Reference Value: N/A.

_____

_____

_____

_____

13. Assessment of Nasal Breathing with Lip Closure (Can the patient close or hold water in his/her mouth for at least 3 minutes?) Purpose: If a subject can breathe through the nose with the lips and mouth closed for three minutes, we can identify patients at risk of mouth breathing. This is a simple and effective screening tool to distinguish organic nasal obstruction from functional mouth breathing habit and or nasal resistance. Reference Value: Patients should be able to comfortably breathe through their nose for at least 3 minutes.

- ○ Yes
- ○ No
- ○ Unable to assess

Nasal Breathing Tape (or Water) Test Measurement (in seconds)

_____

14. Rosenthal Test Purpose: This test can estimate nasal patency and subjectively measure

breathing capacity. Reference Value: Patient should be able keep lips closed for 20 breaths.

- ☐ Remarkable
- ☐ Unremarkable
- ☐ Unable to Assess
- ☐ Not Assessed

15. Cottle Maneuver Purpose: A positive Cottle Maneuver suggests a possible nasal airway obstruction at the nasal valve. A positive Cottle Maneuver could be a sign that the patient may benefit from nasal dilators or strips. If a patient tests positive, an ENT consult may be warranted. Reference Value: Negative.

- ☐ Positive
- ☐ Negative
- ☐ Not assessed

16. Nasal Configuration Upon Forced Inhalation Purpose: Inspiratory collapse with normal inspiratory negative pressure suggests flaccidity of soft tissue and inadequate rigidity of nasal supporting structures. Reference Value: Level 0.

- ☐ Unable to assess
- ☐ Level 0 (Bilateral dilation of the nostrils in inhalation)
- ☐ Level 1 (Neither dilation nor collapse of the nostrils in inhalation)
- ☐ Level 2 (Partial unilateral collapse in inhalation)
- ☐ Level 3A (Partial bilateral collapse)
- ☐ Level 3B (Total unilateral collapse)
- ☐ Level 4 (Total unilateral collapse of one side and partial collapse of other side in inhalation)
- ☐ Level 5 (Bilateral total closure)

17. Guidin Test Purpose: This is a subjective measurement in which compressing the nostril is held closed on one side and slightly compressed on the other side. This movement should elicit the "flaring reflex," which is present in healthy nose-breathing individuals. With poor nasal breathing, the reflex is often diminished or absent. Reference Value: Unremarkable.

- ○ Remarkable
- ○ Unremarkable

18. Mirror Fog Test Purpose: To discriminate between nasal and oral breathing. Reference Value: Fogging should occur near the nose only, indicating that the patient is exclusively nasal breathing.

- ☐ Fogging near nose only
- ☐ Fogging near mouth only
- ☐ Fogging near the nose and mouth
- ☐ Unable to assess

19. Glatzel Mirror Test Purpose: To screen for nasal patency and nasal airway emissions of the right and left nostrils. Reference Value: Even fogging of the mirror. (Note: due to the nasal cycle, it is recommended that these measurements are taken multiple times, at least 2 hours apart.)

- ☐ Even fogging of mirror
- ☐ Uneven fogging of mirror
- ☐ Unable to assess

20. Control Pause Measurement (also known as the "BOLT score," "Breath Hold Time," or "Comfortable Pause") Purpose: High loop gain (one phenotype of obstructive sleep apnea) is

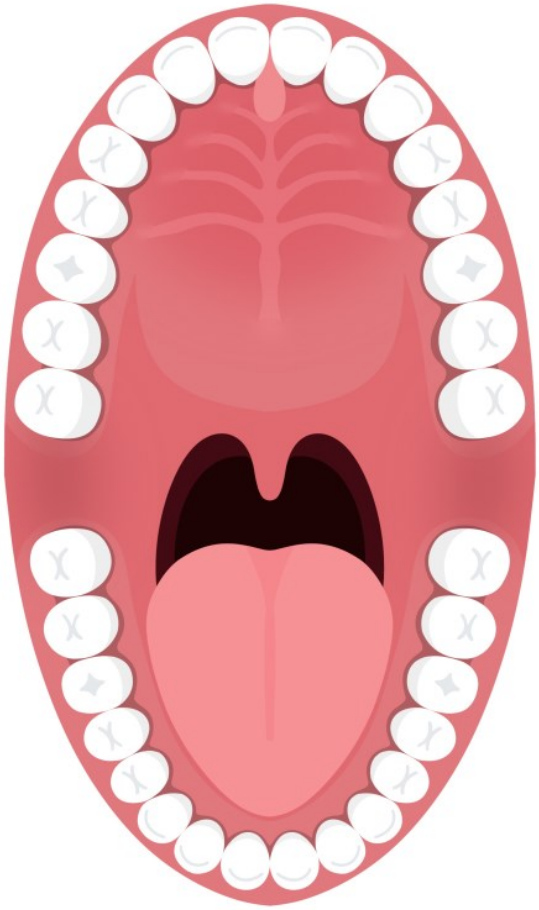
directly related to a low breath-hold time. Loop gain represents respiratory chemosensitivity, so individuals with high loop gain demonstrate exaggerated ventilation in response to minimal increases in carbon dioxide. Reference Value: A breath hold of at least 25 seconds is ideal.

SWALLOWING ASSESSMENTS

The oral phase of the swallow should involve lip closure, equal unilateral chewing, adequate bolus formation in the center of the tongue, jaw closure, tongue elevation to the incisive papilla during the swallow, and clean-up swallows as needed. Most of the skills required for proper feeding and a mature swallow are established by age 2, including tongue elevation and lateralization, tongue/jaw/lip differentiation, and circular rotary chewing patterns.

21.

22. Saliva Swallow Assessment Using Payne Technique Purpose: Orofacial myologists can use this technique to evaluate tongue positioning during saliva swallows. Highlighted are the areas where the tongue tip appears to have touched during saliva swallows. Reference Range: In a normal, mature swallow, the tongue tip should touch "the spot," which is the area at the junction of the incisive papilla and palatal rugae, behind the upper front teeth.



23. Saliva Swallow Assessment

☐ Unable to assess ☐ Tongue touches the incisive papilla for the swallow
☐ Tongue low and forward during the swallow ☐ Difficulty swallowing with the lips opened

Notes on Saliva Swallow

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24. Drinking Assessments

Drinking Assessments (Open Cup)
☐ Not assessed ☐ Unable to assess ☐ Biting on cup (can be a sign of poor jaw stability)
☐ Tongue below cup (can be related to an immature suckling pattern)
☐ Leakage of liquids (can be the result of poor suctioning, ineffective trapping of liquids, or weakness in the lips/cheeks)
☐ Pouching of liquids (can indicate difficulty in managing bolus)
☐ Chewing of liquids (can be a sign of difficulty managing a bolus)
☐ Low/forward tongue during swallow (tongue thrust style swallowing pattern)
☐ Lip smacking (can be a sign of weakness in the perioral musculature or related to malocclusion)
☐ No masseter action during swallowing (this indicates that the teeth did not come together during the swallow as they should)
☐ Grimacing (sign of imbalanced oral and facial muscle use during swallowing)
☐ Choking (could be a sign of an issue with the pharyngeal phase of swallow)

Notes on Open Cup Drinking

Drinking Assessment (With Straw)

☐ Not assessed ☐ Unable to assess ☐ Biting on straw (can indicate poor jaw stability)
☐ Straw behind teeth (can interfere with tongue movement during the swallow)
☐ Leakage of liquids (can be the result of poor suctioning, ineffective trapping of liquids, or weakness in the lips/cheeks)
☐ Pouching of liquids (can indicate difficulty in managing bolus)
☐ Tongue against straw or low/forward tongue during swallow (this is a tongue thrust style swallowing pattern)
☐ Lip smacking (can be a sign of weakness in the personal musculature or related to malocclusion)
☐ Leakage of liquids (can be the result of poor suctioning, ineffective trapping of liquids, or weakness in the lips/cheeks)
☐ Chewing of liquids (can indicate difficulty in managing bolus)
☐ No masseter action during swallowing (this indicates that the teeth did not come together during the swallow as they should)
☐ Grimacing (sign of imbalanced oral and facial muscle use during swallowing)
☐ Choking (could be a sign of an issue with pharyngeal phase of swallow)

Notes on Straw Drinking

Drinking Assessment (Bottle)

☐ Not assessed ☐ Unable to assess
☐ Lips encircle top of bottle (can be related to an immature suckling pattern)
☐ Tongue below lip of bottle (can be related to an immature suckling pattern)
☐ Leakage of liquids (can be the result of poor suctioning, ineffective trapping of liquids, or weakness in the lips/cheeks)
☐ Pouching of liquids (can indicate difficulty in managing bolus)
☐ Low/forward tongue during swallow (tongue thrust style swallowing pattern)
☐ Lip smacking (can be a sign of weakness in the personal musculature or related to malocclusion)
☐ Leakage of liquids (can be the result of poor suctioning, ineffective trapping of liquids, or weakness in the lips/cheeks)
☐ Chewing of liquids (can indicate difficulty in managing bolus)
☐ No masseter action during swallowing (this indicates that the teeth did not come together during the swallow as they should)
☐ Grimacing (sign of imbalanced oral and facial muscle use during swallowing)
☐ Choking (could be a sign of an issue with the pharyngeal phase of swallow)

Notes on Drinking from a Bottle

☐ Patient reports difficulty swallowing pills ☐ Reports no difficulty with swallowing pills
☐ Has not tried pill swallowing before

☐ Does not typically use drinking vessel that could interfere with tongue position during swallowing
☐ Recommend using a different drinking vessel that does not interfere with swallowing

25. Eating Assessments

Evaluation of Pureed-Style Food Consumption

☐ Not assessed ☐ Unable to assess

☐ Tongue comes out to greet spoon (typically the tongue should stay in the mouth in the "ah" position during food intake)

☐ Scrapes teeth on utensil (typically the lips should remove the food from the utensil)

☐ Chews pureed food that does not require chewing (this can be a sign of ineffective bolus management)

☐ Washes down food with water (possible sign of an ineffective swallow)

☐ Grimacing (sign of imbalanced oral and facial muscle use during swallowing)

☐ Choking (could be a sign of an issue with the pharyngeal phase of the swallow)

☐ Lip smacking (can be a sign of weakness in the perioral musculature or related to malocclusion)

☐ Low/forward tongue during swallow (this is a tongue thrust style swallowing pattern)

☐ Scattered bolus (food is not effectively suctioned and trapped to the top of the tongue for evacuation)

☐ No masseter action during swallowing (this indicates that the teeth did not come together during the swallow as they should)

Notes on Pureed-Style Food

Evaluation of Hard/Crunchy Food Consumption

☐ Not assessed ☐ Unable to assess

☐ Tongue protrudes out to greet food (typically the tongue should stay in the mouth in the "ah" position during food intake)

☐ Inadequate chewing of food

☐ Noticeable preference for chewing on one side of the mouth (does not "exercise" the musculature evenly)

☐ Mashing of food with tongue (molars are not being used to chew, possibly due to weakness in the tongue, cheek, or jaw musculature)

☐ Lip smacking (can be a sign of weakness in the perioral musculature or related to malocclusion)

☐ Scattered bolus (food is not effectively suctioned and trapped to the top of the tongue for evacuation)

☐ Washing down of food with drink (could mean that food is not effectively being evacuated and is instead being washed away)

☐ Too large of bites (too much food can make suctioning and trapping difficult)

☐ Mouth consistently open during chewing (inefficient chewing possibly related to an airway issue; often associated with weak lip, cheek, or jaw musculature)

☐ Lip smacking (can be a sign of weakness in the perioral musculature or related to malocclusion)

☐ Head movements during food manipulation or swallowing (poor dissociation of muscle movements; could be using body movements to manipulate and move food)

☐ Low, forward tongue position during swallowing (tongue thrust style swallow)

☐ Choking (could be a sign of an issue with the pharyngeal phase of the swallow)

☐ No masseter action during swallowing (this indicates that the teeth did not come together during the swallow as they should)

Notes on Hard/Crunchy Food

Evaluation of Juicy/Complex Food Consumption

☐ Not assessed ☐ Unable to assess ☐ Tongue protrudes out to greet food ☐ Inadequate chewing of food
☐ Significant preference for chewing on one side of the mouth (does not "exercise" the musculature evenly)
☐ Mashing of food with tongue (molars are not being used to chew, possibly due to weakness in the tongue, cheek, or jaw musculature)
☐ Scattered bolus (food is not effectively suctioned and trapped to the top of the tongue for evacuation)
☐ Washing down of food with drink (could mean that food is not effectively being evacuated and is instead being washed away)
☐ Too large of bites (too much food can make suctioning and trapping difficult)
☐ Mouth consistently open during chewing (inefficient chewing possibly related to an airway issue; often associated with weak lip, cheek, or jaw musculature)
☐ Lip smacking (can be a sign of weakness in the perioral musculature or related to malocclusion)
☐ Choking (could be a sign of an issue with the pharyngeal phase of the swallow)
☐ Head movements during food manipulation or swallowing (poor dissociation of muscle movements; could be using body movements to manipulate and move food)
☐ Low, forward tongue position during swallowing (tongue thrust style swallow)

Notes on Juicy/Complex Food

ORAL FUNCTION ASSESSMENTS

Oral function assessments are done with minimal guidance and are used to assess basic movements of the tongue, lip, and jaw independently and as a functional unit.

26. Functional Activity Assessment

Functional Activities	Good	Needs Work	Unable to Assess	Notes
Hold tongue still for 5 seconds (assesses tongue strength)				
Side to side (assesses tongue strength and tongue/lip/jaw disassociation during lateralization)				
In and out (assesses tongue strength and tongue/lip/jaw disassociation)				
Up and down (assesses tongue strength, tongue/lip/jaw disassociation, and for tongue thrusting forward during LA TA DA or NA sounds)				
Fat/skinny (assesses intrinsic tongue muscle function for tongue shaping and tongue/lip/jaw disassociation)				
Tongue bowl (assesses tongue/lip/jaw disassociation, intrinsic tongue muscle function for shaping, and independent movement of the tip, blade, and body of the tongue)				
Tongue taco (assesses tongue/lip/jaw disassociation, intrinsic tongue muscle function for shaping, and independent movement of the tip, blade, and body of the tongue)				

Suction flat for a minimum of 30 seconds (assesses strength of tongue and palate size accommodations for the tongue)				
Anterior/front of tongue suction release (assesses the ability to suction as well as the ability to differentiate movements of the front and back of the tongue)				
Posterior/back of tongue suction release (assesses the ability to suction as well as the ability to differentiate movements of the front and back of the tongue)				
Quick suction pops (ability to generate intraoral suction with the tongue tip on the incisive papilla)				
Long suction hold (ability to generate intraoral suction with the tongue tip on the incisive papilla)				
Whistle (ability to round lips, control air flow)				

EXTRA-ORAL ASSESSMENTS

Extra-oral assessments can provide insight into orofacial muscle function and dysfunction as well as craniofacial growth/development patterns.

27. Extra-Oral Photos

28. Extra Oral Observations

- ☐ Enlarged nasal bridge
- ☐ Upturned nose
- ☐ Allergic shiners
- ☐ Crease on nose "allergic salute"
- ☐ Uneven masseter strength
- ☐ Visible sclera under iris
- ☐ Red eyes
- ☐ Downturned lateral acanthi
- ☐ Lip incompetence
- ☐ Lip impingement
- ☐ Wears glasses
- ☐ Saddle nose
- ☐ Dorsal hump

29. Jaw Opening Assessment

- ○ Deviation to the right
- ○ Deviation to the left
- ○ Deflection to the right
- ○ Deflection to the left
- ○ Straight opening
- ○ Unable to assess

30. Other Jaw Observations

- ☐ Pain _____
- ☐ Clicking or popping _____
- ☐ Crepitus _____
- ☐ Trismus/limited opening _____
- ☐ Midline shift _____

INTRA-ORAL ASSESSMENTS

The mouth is the window to your health!

31. Intra-Oral Photos

32. Dental Measurements

Measurement Type	Measurement (in millimeters)
Diasthema	
Open bite Reference Value: No open bite is considered normal	
Overjet Reference Value: 2-4mm is considered normal	
Overbite Reference Value: 2-4mm is considered normal	
Maxillary Intercanine Distance (palate width from canine to canine) Reference Value for Adults: a. >37mm (wide) b. 31-37mm (neutral) c. <31mm (narrow)	
Maxillary Intermolar Distance/Palate width (Palate width from 1st molar mesiobuccal cusp to 1st molar mesiobuccal cusp) Reference Value for Adults: a. >52 (wide) b. 46-52mm (neutral) c. <46mm (narrow)	
Mew Growth Indicator Ruler/OrthO2Health™ Barometers /Orthotropic Growth Guide Reference Value: Add 23 to the patient's age for a boy and 21 for a girl That number should be 28mm at the age of 5 and increase 1mm each year until puberty when it should be ideally 38mm for an average sized boy and 36 for a girl. For females 21+years of age, the adult ideal is 36-40mm, and it should be 38-42mm for males. 5mm over ideal may suggest existing or future problems with development of the face, jaws, and airway.	

33. Dentition Assessment

- ☐ Deciduous dentition
- ☐ Mixed dentition
- ☐ Full permanent dentition
- ☐ In braces
- ☐ Attrition
- ☐ Possible acid erosion

- ☐ Patient reports dry mouth

34. Palate and Alveolar Bone

- ☐ High, narrow, V-shaped palate
- ☐ Broad, U-shaped palate
- ☐ Channel palate
- ☐ Bubble palate
- ☐ Cleft palate
- ☐ Prominent suture line
- ☐ Torus palatinus
- ☐ Torus mandibularis
- ☐ Exostoses
- ☐ Pronounced rugae
- ☐ Weak velum
- ☐ Strong gag reflex
- ☐ Palatal overflow
- ☐ Bifid uvula

35. Oropharynx Assessments

	0	I	II	III	IV	Unable to Assess
Mallampati airway score a. Class I: Complete visualization of the soft palate b. Class II: Complete visualization of the uvula c. Class III:Visualization of only the base of the uvula d. Class IV: Soft palate is not visible at all						
Friedman tongue position score a. Class I: Entire uvula and tonsils are visible b. Class II: Most or all of the uvula is visible but tonsils are not visible c. Class III: Soft palate is visible but the uvula is not d. Class IV: Only the hard palate is visible						
Brodsky tonsil grading system a. Grade 0: Surgically removed tonsils b. Grade 1: Tonsils hidden within the pillars c. Grade 2: Tonsils extending to the pillars d. Grade 3: Tonsils are beyond the pillars but not to the midline e. Grade 4: Tonsils extend to the midline.						

36. Tongue Assessments

- ☐ Full Scalloping
- ☐ Partial Scalloping
- ☐ Coated Tongue

37. Tongue Measurements

Measurement Type	Measurement	Compensations? (Present or Absent)	Tension (Present or Absent)	TRMR-TIP	TRMR-LPS
Maximum Interincisal Opening Measured in millimeters. Reference Value: 45-60 is the normal maximum opening for an adult. Reduced mouth opening ("trismus") is 20mm or less.					
Maximum Opening With Tongue Touching					

the Incisive Papilla Measured in millimeters.					
Maximum Opening With Tongue Suctioned Measured in millimeters.					
Kotlow Free Tongue Measurement Measured in millimeters. Reference Value: At least 16mm is ideal. a. Class I (Mild): 12-16mm b. Class II (Moderate): 8-11mm c. Class III (Severe): 3-7mm d. Class IV (Complete Ankyloglossia					
TRMR-TIP (TRMR-TIP= Maximum Opening with Tongue Touching the Incisive Papilla ÷ Maximum Interincisal Opening.) Answer is provided as a percentage. This assesses range of motion of the anterior/front of the tongue. Reference Value: At least 50% is ideal, without compensations or tension. a. Grade 1 (Significantly Above Average): >80% b. Grade 2 (Average): 50-80% c. Grade 3 (Below Average): <50% d. Grade 4 (Significantly Below Average): <25% or Unable to Sustain					
TRMR-LPS (TRMR-LPS= Maximum Opening with Tongue Suctioned ÷ Maximum Interincisal Opening.) This assesses range of motion of the posterior/back of the tongue. Answer is provided as a percentage. Reference Value: At least 30% is ideal, without compensations or tension. a. Grade 1 (Significantly Above Average): >60% b. Grade 2 (Average): 30-60% c. Grade 3 (Below Average): <30% d. Grade 4 (Significantly Below Average): <5% or Unable to Sustain					

38. Lingual Frenum Description

Relevant Descriptors

☐ Thick ☐ Taut ☐ Short ☐ Eiffel tower ☐ Stringy ☐ Submucosal ☐ Restricted ☐ Wispy

39. Lingual Frenum Assessments (Please note that it is typically recommended to do a few sessions of orofacial myofunctional therapy before a tongue tie release. Your orofacial myologist will collaborate with you and the release provider of your choice to determine the ideal time.)

- ○ Lingual frenulum within normal limits
- ○ Restrictive lingual frenum that appears to impact function
- ○ Re-evaluate after initiating orofacial myofunctional therapy for a few weeks

40. Lip Measurements

Measurement Type	Measurement
Philtrum length (in millimeters)	
Upper lip length (in millimeters)	
Lower lip length (in millimeters)	
Percentage of incisor show	
Lip strength (in pounds) Reference Value: 3-5 pounds is considered average	

41. Lip and Cheek Assessments

- ☐ Deviation when smiling
- ☐ Lip impingement
- ☐ Drooling
- ☐ Chapped lips
- ☐ Short upper lip
- ☐ Lip roping
- ☐ Lip incompetence (mentalis strain upon closing)
- ☐ Unable to maintain seal with gentle pressure applied to cheeks puffed with air
- ☐ Excessive gingival display
- ☐ Rash around lips or in corner of lips
- ☐ Unable to lift 1 cheek at a time
- ☐ Diasthema

42. Labial Frenula Assessments

- ☐ Labial frenula within normal limits
- ☐ Low maxillary labial frenal attachment
- ☐ High mandibular labial frenal attachment

43. Buccal Frenula Assessments

- ☐ Buccal frenula within normal limits
- ☐ High maxillary buccal frenal attachment
- ☐ Low maxillary buccal frenal attachment

PLAN

Our program:

Our full orofacial myofunctional therapy program is 4 phases in length and typically involves weekly appointments with individualized exercises and other interventions over the course of 12-20 weeks.

- **Phase 1:** This phase is exercise intensive. During this phase, we break down the basic movements for a good swallow and oral rest posture (tongue up, lips closed, breathing through the nose, and the

upper/lower teeth a few millimeters apart).

- **Phase 2:** This phase involves functional performance. During this phase, we piece together the things we have learned in phase 1 to achieve more complex muscle activities. This includes oral rest posture for longer periods of time and balanced muscle functions during activity. We may work on saliva swallows, balanced unilateral chewing, bolus formation, eating and drinking. For individuals with speech and articulation concerns, treatment with the speech-language pathologist can begin during phase two, after oral rest posture has been established.
- **Phase 3:** This phase focuses on the habituation of good oral rest posture (day and night) and swallows during all meals.
- **Phase 4:** This phase involves maintenance and habituation of all learned skills.

The main goals of this treatment are:

1. The habituation of oral rest posture, including nasal breathing, lip competence and maintenance of lip seal/closure, high/palatal tongue rest posture, and a few millimeters of freeway space between the upper and lower teeth.
2. Optimization of chewing and swallowing functions. This includes the ability to properly accept food from a spoon or fork, even chewing patterns, bolus control and formation, good swallows for all foods and drinks, clean-up swallows as needed, and proper saliva swallows.

Orofacial myofunctional therapy has been associated with incidental gains in things we do not directly treat. For example, lessening the severity of sleep disordered breathing (including snoring, upper airway resistance syndrome, and obstructive sleep apnea), reducing TMJ pain, improving oral health, facilitating orthodontic treatment, and decreasing the chances of orthodontic and surgical relapse.

Please contact us with any questions regarding your care.

44. Status of Treatment

☐ Orofacial myofunctional therapy is indicated and can commence immediately
☐ Patient is currently scheduled to begin active treatment at our office
☐ Orofacial myofunctional therapy is indicated, but it is currently recommended that the patient wait to begin treatment
☐ Orofacial myofuctional therapy is not recommended for this patient

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Referrals Provided

☐ ENT ☐ Allergist ☐ Oral Surgeon ☐ Periodontist ☐ Speech-Language Pathologist ☐ Dentist
☐ Neuromuscular Dentist ☐ Other

Prognosis With Treatment

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Hopeless

Prognosis Without Treatment

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Hopeless

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45. Short-Term Goals

- ☐ Consistently touch "the spot" at least 10x
- ☐ Elevate the tongue to the "the spot" comfortably for at least 60 seconds
- ☐ Be able to sustain a strong, even suction for a minimum of 60 seconds
- ☐ Be able to dissociate movements of the tongue from the lips and jaw in all 3 planes of movement (lateral, horizontal, and vertical), 10x
- ☐ Be able to shape the tongue into a steady bowl for a minimum of 15 seconds
- ☐ Differentiate movements of the tongue tip, tongue blade, and tongue body by holding the tongue in the shape of a taco for at least 15 seconds
- ☐ Be able to generate intra oral pressure with the tongue on "the spot" ☐ Strengthen the lips to 3-5lbs
- ☐ Comfortably achieve good oral rest posture (including palatal tongue position) for a minimum of 30 minutes
- ☐ Achieve comfortable pause of at least 25 seconds
- ☐ Strengthen the tongue enough to hold it flat and steady, without support, for at least 5 seconds
- ☐ Be able to suction and trap water and saliva to the top of the tongue for swallowing at least 10x
- ☐ Be able to differentiate movement of different parts of the tongue with "tick tocks" or "anterior and posterior suction releases"
- ☐ Eliminate nail biting habit ☐ Eliminate thumb sucking habit ☐ Eliminate finger sucking habit
- ☐ Eliminate pacifier habit ☐ Eliminate chewing habit ☐ Stop leaning head on hand
- ☐ Prepare the myofascia, practice suctioning, maximize function and reduce compensatory movements as much as possible before surgery
- ☐ Guide the healing process, maximize function and reduce compensatory movements after surgery

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Long-Term Goals

- ☐ Habituate nasal breathing (90% of the time — day and night)
- ☐ Habituate proper tongue rest posture (90% of the time — day and night)
- ☐ Reduce episodes of stress-based nocturnal and diurnal bruxism and habituate the establishment of freeway space (90% of the time)
- ☐ Reduce tongue thrusting that occurs during all meals and snacks to less than 10% ☐ Swallow a pill

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REFERENCES

1. F-Air-EST 21
http://www.fairest.org/tools/

2. McKeown, P., et al. (2021). Breathing re-education and phenotypes of sleep apnea: A Review. Journal of Clinical Medicine, 10(3), 471. https://doi.org/10.3390/jcm100...
https://bit.ly/3twgHrU

3. Mason, R. M. (2020). The importance of the freeway space in ENT evaluations of airway interferences. Online Journal of Otolaryngology and Rhinology, 3(1). https://doi.org/10.33552/ojor.... https://bit.ly/3MXs5oo

4. Mason, R., Franklin, H., Grant, P., & Role, E. (2020). The importance of the freeway space in orofacial myofunctional therapy. International Journal of Orofacial Myology and Myofunctional Therapy, 46(1), 37–47. https://doi.org/10.52010/ijom....
https://bit.ly/3q8kPMA

5. Guilleminault, C., et al. (2017). Toward a functional definition of ankyloglossia: Validating current grading

scales for lingual frenulum length and tongue mobility in 1052 subjects. Sleep and Breathing, 21(3), 767–775. https://doi.org/10.1007/s11325...
https://bit.ly/3jyjuex

6. Zaghi, S., Shamtoob, S., Peterson, C., Christianson, L., Valcu-Pinkerton, S., Peeran, Z., Fung, B., Kwok-keung Ng, D., Jagomagi, T., Archambault, N., O'Connor, B., Winslow, K., Lano, M., Murdock, J., Morrissey, L., & Yoon, A. (2021). Assessment of posterior tongue mobility using lingual-palatal suction: Progress towards a functional definition of ankyloglossia. Journal of Oral Rehabilitation, 48(6), 692–700. https://doi.org/10.1111/joor.1..
https://bit.ly/3JeecPy

7. Moschik, C. (2015). Influence of myofunctional therapy on Upper Intercanine distance. Journal of Dentistry, Oral Disorders & Therapy, 3(1), 01–07. https://doi.org/10.15226/jdodt...
https://bit.ly/35QLnev

8. Paskay, L. (2006). Instrumentation and measurement procedures in Orofacial Myology. *International Journal of Orofacial Myology*, *32*(1), 37–57. https://doi.org/10.52010/ijom....
https://bit.ly/3jhGXQY

9. Paskay, L. (2012). A one-page orofacial myofunctional assessment form: A proposal. *International Journal of Orofacial Myology*, *38*(1), 27–37. https://doi.org/10.52010/ijom....
https://bit.ly/3DUttUz

10. Grandi, D. (2012). The "interdisciplinary orofacial examination protocol for children and adolescents": A resource for the interdisciplinary assessment of the stomatognatic system. *International Journal of Orofacial Myology*, *38*(1), 15–26. https://doi.org/10.52010/ijom...
https://bit.ly/37oXNdS

11. Pacheco, M. C., Casagrande, C. F., Teixeira, L. P., Finck, N. S., & Araújo, M. T. (2015). Guidelines proposal for clinical recognition of Mouth Breathing Children. *Dental Press Journal of Orthodontics*, *20*(4), 39–44. https://doi.org/10.1590/2176-9...
https://bit.ly/3DYI9SQ

12. Zaghi, S., Peterson, C., Shamtoob, S., Fung, B., Kwok-keung Ng, D., Jagomagi, T., Archambault, N., O'Connor, B., Winslow, K., Peeran, Z., Lano, M., Murdock, J., Valcu-Pinkerton, S., & Morrissey, L. (2020). Assessment of nasal breathing using lip taping: A simple and effective screening tool. *International Journal of Otorhinolaryngology*, *6*(1), 10. https://doi.org/10.11648/j.ijo.
https://bit.ly/3KmeFAC

13. McKeown, P., O'Connor-Reina, C., & Plaza, G. (2021). Breathing re-education and phenotypes of sleep apnea: A Review. *Journal of Clinical Medicine*, *10*(3), 471. https://doi.org/10.3390/jcm100..
https://bit.ly/3r6mnao

14. Hockenbury, D. (2018). Can We 'Grow Lips' In Therapy? The Efficacy of Lip Stretching and Strengthening Exercises in Patients with Lip Incompetence. *Journal of Dental and Oral Health*, *4*(4), 120.
https://bit.ly/3xhxtNT

15. RDH Magazine. (2019, December 2). *Eye spy: What the eyes can tell us about the mouth ...* Retrieved from https://www.rdhmag.com/patient...
https://bit.ly/3r9hwoS

16. Boshart, C. (n.d.). *The MyoFunctional Evaluation* (3rd ed.).

17. Physiopedia. https://bit.ly/3xbYLmP

18. Fung, B., et al. (2020). Assessment of nasal breathing using lip taping: A simple and effective screening tool. International Journal of Otorhinolaryngology, 6(1), 10. https://doi.org/10.11648/j.ijo...

https://bit.ly/3LbpsO8

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