Get Started Guide

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Orofacial Myofunctional Therapist
Flow Myofunctional Therapy

Welcome to Flow Myofunctional Therapy!

I'm happy you're here!

Hello! I'm Kelsey, your orofacial myofunctional therapist!

I'm excited you are here and would like to welcome you to the exciting world of myofunctional therapy! Together we will uncover and work to correct any myofunctional impairments you may have, so that you can FLOW through life at your best!

I created this guide to help you through getting set up with therapy, and give you some more information about the process.

I can't wait to get to know you and be a part of your journey towards optimum wellness, health, and wellbeing!

Are you ready? Lets FLOW!

Kelsey

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Orofacial Myofunctional Therapist
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Expectations

Like anything in life, you get out what you put in. Myofunctional therapy is no different. You have to be ready and willing to put in the work. If you do, you will see results. If you don't, you may not reach your therapy goals. If you go beyond what is asked, you will have great results!

Once you begin therapy, a personalized program is designed for you and your needs. Each session's exercises build upon the last, and you must have the self-motivation between sessions to do the work so that we can progress!

If you are a parent on this journey with your child, you have to be all in and committed 150% to supporting your child and their success in the program. You play an integral role in their therapy!

Lets get going!

Where to Start

Complete Discovery Paperwork

FULLY complete paperwork and email back to me at kelsey@flowmyofunctionaltherapy.com

You will need to print the appropriate pages and LEGIBLY fill them out. Please see info below for which questionnaires are required based on client age. Some questions may seem repetitive, but please fill everything out completely and to the best of your ability. Feel free to add additional information if necessary.

- **Discovery Paperwork Checklist (everyone)** is a checklist of history/symptoms that I use to identify myofunctional impairment
- **Pittsburgh Sleep Quality Index (ages 18+)** evaluates your *sleep quality*
- **Epworth Sleepiness Scale (ages 18+)** evaluates your *daytime sleepiness*
- **Fatigue Severity Scale (ages 18+)** evaluates *impact of fatigue* on you
- **Sleep Hygiene Index (ages 18+)** helps us to plan sleep health promotion strategies
- **Quality of Life Scores (everyone)** helps to identify what you see as a problem
- **Pediatric Sleep Questionnaire (under 18)** is used to identify sleep concerns in children

Submit your paperwork as soon as you have it done!
Please return documents in PDF format.
There are many free and simple apps that can turn your phone into a scanner that allow you to scan and save as a PDF (I use Adobe Scan). This allows me to file your paperwork correctly.

Where to Start

ADD ME ON SKYPE

Search Flow Myofunctional Therapy or use this link:
https://join.skype.com/invite/h8C7Z61CEucB

Please do this ahead of your appointment! Better yet, test it out with a friend or family member first so we don't waste any of your valuable appointment time with tech issues!

LEARN MORE

Please write down questions and have them ready when its time for your complementary assessment or comprehensive exam!

Visit flowmyofunctionaltherapy.com for more resources!

Below you will find additional information about therapy packages, prices and other important topics you may find helpful.

The FlowMyo Process

STEP 1
Complimentary Assessment

- Hit the "high points" of your Discovery Paperwork
- Make sure we are a good client/therpist match
- Decide if moving on to a comprehensive exam makes sense for you

STEP 2
Comprehensive Exam

- Discuss Discovery Paperwork/photos in more detail
- Discuss therapy goals
- Breathing demonstration
- Functional Assessment
- Choose therapy package

STEP 3
Kit, Photos, Prepare

- Receive your kit
- Take additional photos required to start therapy
- Watch "Welcome to Therapy" video
- Schedule your first session!

STEP 4
Phase 1 Therapy

- Frenectomy prep if needed (about 8 weeks)
- Begin working on coordination and strength, proprioception, and neuromuscular connections
- TMD work

STEP 5
Comprehensive Therapy

- Snoring/Sleep Apnea
- Breath Work
- Sleep Health Promotion
- Behavior Modification
- Swallow
- Eustachian Tube Dysfunction

Depending on your chosen therapy program, duration is either 6 months or 1 year.
Preparation for a frenectomy (togue-tie release) is about 8 weeks.

Current Pricing

During your comprehensive exam, we discuss which program is best for you based on your personality, learning style, and support needs.

ADULT THERAPY

COMPREHENSIVE

1 year, unlimited sessions

1:1, 30 minute sessions

$2250

PHASE 1

6 months, 10-12 sessions

1:1, 30 minute sessions

$1550

Therapy plans are customized to each individual's needs and therapy goals.

YOUTH THERAPY

COMPREHENSIVE (9-18)

1 year, unlimited sessions

1:1, 30 minute sessions

$2250

FLOWMYO MINI (4-8)

1 year, unlimited sessions

1:1, 30 minute sessions

$1225

Payment due before beginning therapy.

Payment plans and family discounts available.

Discovery Paperwork Checklist

Please check any/all that apply. It is very important to **FULLY COMPLETE** this paperwork **LEGIBLY**.

Name:
Today's Date:
DOB:
Age:
Were you referred by someone? ________________________________
Would you like me to communicate with your doctor? Yes / No
Dr. Name: ____
Dr. Email: ____
Where do you live? This helps me know if I have a provider / partner in your area. ____

Infancy/Early Childhood

- ☐ Difficulty nursing or used a nipple shield
- ☐ Fall asleep while nursing or need to nurse frequently
- ☐ Bottle-fed more than 50% of the time
- ☐ Had trouble with (or medicated for) reflux
- ☐ Colic symptoms or crying a lot, and unhappy
- ☐ Spit up often
- ☐ Gassy
- ☐ Messy feeding
- ☐ Chronic congestion
- ☐ Gagging/choking/coughing when eating
- ☐ Noisy / mouth breathing
- ☐ Multiple ear infections
- ☐ Tubes placed
- ☐ Difficulty transitioning to solid foods
- ☐ Other:

Airway / Breathing Concerns

- ☐ Asthma or any other breathing condition ___________________
- ☐ Allergies
- ☐ Dry, chapped lips
- ☐ Chronic congestion, unmedicated
- ☐ Chronic congestion, medicated
- ☐ Deviated septum
- ☐ Nasal surgery completed, details ________________________
- ☐ Nasal surgery recommended, details ______________________
- ☐ Tonsils removed
- ☐ Adenoid removed
- ☐ Tonsils enlarged
- ☐ Estimated % of **daytime** NASAL breathing? _________
- ☐ Estimated % of **nighttime** NASAL breathing? _________
- ☐ Trouble catching breath
- ☐ Over breathing/sighing
- ☐ Other:

Oral Resting Posture

- ☐ Full tongue rests on the roof of the mouth
- ☐ Full tongue rests in the middle of the mouth
- ☐ Full tongue rests on the floor of the mouth
- ☐ The tongue pushes on teeth
- ☐ Resting mouth posture is mouth closed with lips completely sealed
- ☐ Resting mouth posture is mouth closed with lips MOSTLY sealed
- ☐ Resting mouth posture is mouth open and lips open
- ☐ The lips are unable to close
- ☐ Other:

Digestive / Eating Behaviors / Chewing / Swallowing

- ☐ Frequent digestive issues
- ☐ Reflux: unmedicated
- ☐ Reflux: medicated
- ☐ Bloating
- ☐ Burping
- ☐ Hiccupping
- ☐ Gas
- ☐ Constipation
- ☐ Slow, adequate chewing on BOTH sides of the mouth
- ☐ Poor, quick chewing or chewing on one side of the mouth
- ☐ Slow eating behaviors because eating is a chore
- ☐ Rapid eating behaviors because I'm in a hurry to swallow
- ☐ Tongue thrusts forward during swallowing
- ☐ The back of the tongue doesn't lift during swallowing
- ☐ Difficulty with breathing while eating
- ☐ Open mouth chewing
- ☐ Use of liquids to swallow
- ☐ Difficulty swallowing pills
- ☐ Strong gag reflex
- ☐ Picky with textures
- ☐ Choking
- ☐ Prefer soft/easy to chew foods
- ☐ Eustachian tube concerns?
- ☐ Other:

Tongue-Tie History

- ☐ Lingual frenectomy as a baby
- ☐ Family members with tongue-ties
- ☐ Tongue-tie previously diagnosed by_______________________
- ☐ Labial / buccal tie suspected
- ☐ Previous frenectomy? When? ____________________________
- ☐ Previous myofunctional therapy? When? ___________________

Sucking/ Toxic Oral Habits

- ☐ Thumb/finger sucking
- ☐ Prolonged pacifier use
- ☐ Another habit: ______________________________________

Dental / Orthodontic History

- ☐ For children under 18, age of first orthodontic exam?__________
- ☐ Previous orthodontic treatment, when? ____________________
- ☐ Experiencing orthodontic relapse
- ☐ Previous cervical headgear
- ☐ Previous expansion completed, when? ____________________
- ☐ Expansion recommended
- ☐ High, narrow palate
- ☐ Dental crowding
- ☐ Permanent teeth extracted (other than wisdom teeth)
- ☐ Wisdom teeth extracted
- ☐ Using an oral appliance:
- ☐ Tongue crib or past habit corrector
- ☐ Past jaw surgery, when? ______________________________
- ☐ Recommended jaw surgery _____________________________
- ☐ High decay rate
- ☐ Can't reach the back molars with the tip of the tongue
- ☐ Small, recessed jaw

Speech

- ☐ History of speech therapy
- ☐ Trouble with certain sounds, what? ______________________
- ☐ Difficulty speaking fast
- ☐ Speech delay
- ☐ Stuttering / mumbling
- ☐ Trouble projecting voice

TMJ / TMD

- ☐ TMJ treatment past
- ☐ TMJ treatment current
- ☐ Very strong pain
- ☐ Intense, throbbing
- ☐ Moderate pain
- ☐ Mild pain
- ☐ Paresthesia
- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Acute inflammation (less than 2 weeks)
- ☐ Chronic inflammation (longterm, ongoing)
- ☐ Sharp and localized pain
- ☐ Pain on movement
- ☐ Pain reduced with rest
- ☐ Dull ache
- ☐ Diffuse (spread out) pan/ache
- ☐ Stiffness
- ☐ Deep ache, often at rest
- ☐ Inconsistent, variable pain
- ☐ Tenderness of the skin in area of pain
- ☐ "Knife-like" pain symptoms

Sleep

- ☐ Quiet sleeping at night with mouth closed, lips sealed
- ☐ Occasional snoring
- ☐ Frequent, snoring/loud breathing > 3 nights per week
- ☐ Loud snoring can be heard through a wall or door
- ☐ Has anyone ever said that you gasp or stop breathing?
- ☐ Sleep in strange positions
- ☐ Wakes easily or often
- ☐ Prolonged bedwetting
- ☐ Wakes tired and not refreshed
- ☐ Restless sleeping
- ☐ Tooth grinding/clenching
- ☐ Grinding appliance
- ☐ Sleeps with mouth open
- ☐ Sleep apnea test taken, when? __________________________
- ☐ Previous sleep-disordered breathing diagnosed, when and what?
  ____
- ☐ Fatigue/daytime drowsiness
- ☐ Snoring appliance
- ☐ Frequent urination
- ☐ Night terrors
- ☐ Night sweats
- ☐ Wakes with headache
- ☐ Mouth taping at night?
- ☐ Sleep aid/CBD/melatonin at night?
- ☐ Are you male with a collar size > 17 inches?
- ☐ Are you female with a collar size > 16 inches?
- ☐ BMI greater than 30
- ☐ Being treated for hypertension
- ☐ Being treated for diabetes
- ☐ Being treated for heart disease
- ☐ Being treated for Alzheimer's/ dementia
- ☐ Being treated for anxiety
- ☐ Being treated for depression
- ☐ Being treated for chronic pain

Behavior Challenges / Stress

- ☐ Sensory processing
- ☐ Oppositional defiance
- ☐ Hyperactivity / Inattention
- ☐ Average stress level in last month (10 high, 1 low) ____________
- ☐ Other:

Head / Neck / Tension (Adults)

- ☐ Frequent headaches
- ☐ Jaw / facial pain / tension
- ☐ Clenching / grinding
- ☐ Neck tension / pain
- ☐ Shoulder tension
- ☐ Forward head posture
- ☐ Slouching

Medical Conditions & Medications

Who Else is On Your Healthcare Team? (Chiro, massage therapist, physical therapist, myofascial release, etc)

Any Additional Information

Name____ Date_________

Sleep Quality Assessment (PSQI)

What is PSQI, and what is it measuring?

The Pittsburgh Sleep Quality Index (PSQI) is an effective instrument used to measure the quality and patterns of sleep in adults. It differentiates "poor" from "good" sleep quality by measuring seven areas (components): subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medications, and daytime dysfunction over the last month.

INSTRUCTIONS:

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month,

1. When have you usually gone to bed? ____________________
2. How long (in minutes) has it taken you to fall asleep each night? ____________________
3. What time have you usually gotten up in the morning? ____________________
4. A. How many hours of actual sleep did you get at night? ____________________
   B. How many hours were you in bed? ____________________

5. During the past month, how often have you had trouble sleeping because you	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
A. Cannot get to sleep within 30 minutes				
B. Wake up in the middle of the night or early morning				
C. Have to get up to use the bathroom				
D. Cannot breathe comfortably				
E. Cough or snore loudly				
F. Feel too cold				
G. Feel too hot				
H. Have bad dreams				
I. Have pain				
J. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason (s):				
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
9. During the past month, how would you rate your sleep quality overall?	Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)

Scoring

Component 1	#9 Score	C1 ___________
Component 2	#2 Score (<15min (0), 16-30min (1), 31-60 min (2), >60min (3)) + #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3)	C2 ___________
Component 3	#4 Score (>7(0), 6-7 (1), 5-6 (2), <5 (3)	C3 ___________
Component 4	(total # of hours asleep) / (total # of hours in bed) x 100 >85%=0, 75%-84%=!, 65%-74%=2, <65%=3	C4 ___________
Component 5	# sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3)	C5 ___________
Component 6	#6 Score	C6 ___________
Component 7	#7 Score + #8 score (0=0; 1-2=1; 3-4=2; 5-6=3)	C7 ___________

Add the seven component scores together ________________ ***Global PSQI*** ______________

A total score of "5" or greater is indicative of poor sleep quality.

If you scored "5" or more it is suggested that you discuss your sleep habits with a healthcare provider

Patient Name: ________________________ DOB: __________ Date: __________

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never dose
2 = moderate chance of dozing
1 = slight chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0-3)**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place --- for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
Total Score:	

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness. A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Patient Name: ________________________ DOB: __________ Date: __________

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire

During the past week, I have found that:	**Disagree ⟷ Agree**						
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
Total Score:							

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your score.

The fatigue Severity Scale key

A total score of less than 36 suggests that you may not be suffering from fatigue.
A total score of 36 or more suggests that you may need further evaluation by a physician.

Your next steps

This scale should not be used to make your own diagnosis.
If your score is 36 or more, please share this information with your physician. Be sure to describe all your symptoms as clearly as possible to aid in your diagnosis and treatment.

SLEEP HYGIENE INDEX (SHI)

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale to make your choice.

0	1	2	3	4
Never	**Rarely**	**sometimes**	**Frequent**	**Always**

Statement						
1. I take daytime naps lasting two or more hours.	0	1	2	3	4	________
2. I go to bed at different times from day to day.	0	1	2	3	4	________
3. I get out of bed at different times from day to day.	0	1	2	3	4	________
4. I exercise to the point of sweating within 1 hr of going to bed.	0	1	2	3	4	________
5. I stay in bed longer than I should two or three times a week.	0	1	2	3	4	________
6. I use alcohol, tobacco, or caffeine within 4hrs of going to bed or after going to bed.	0	1	2	3	4	________
7. I do something that may wake me up before bedtime (for example: play video games, use the internet, or clean).	0	1	2	3	4	________
8. I go to bed feeling stressed, angry, upset, or nervous.	0	1	2	3	4	________
9. I use my bed for things other than sleeping or sex (for example: watch television, read, eat, or study).	0	1	2	3	4	________
10. I sleep on an uncomfortable bed (for example: poor mattress or pillow, too much or not enough blankets).	0	1	2	3	4	________
11. I sleep in an uncomfortable bedroom (for example: too bright, too stuffy, too hot, too cold, or too noisy).	0	1	2	3	4	________
12. I do important work before bedtime (for example: pay bills, schedule, or study).	0	1	2	3	4	________
13. I think, plan, or worry when I am in bed.	0	1	2	3	4	________

Total score =___________

Quality of Life Scores:
These are common issues rated on a 1 (no problem) to 10 (significant problem) scale.

Please enter today's date at the top, and then please rate each box in that column with a number between 1 and 10 based upon what your experience is.

10 means it is a significant problem, 1 means there is not a problem.

Date				
...breathing through the nose. (congestion, colds, earaches, swollen tonsils, infections)				
...keeping lips together at rest (open mouth, lips apart at rest, chapped lips)				
...chewing & swallowing (uses face muscles, sloppy, noisy, quickly, drooling, tongue-tie)				
...sitting and standing with good posture (slouching, forward head, aches or pains)				
...eating and nutrition (picky, difficulty chewing, not nutritious, digestive issues)				
...daytime breathing (asthma, allergies to food, pollen, animals, toxins, parasites)				
...getting a good night's sleep (restless, snoring, messing bed, awakening, accidents)				
...breathing while sleeping (snoring, heavy breathing, open mouth)				
...body aches or pains (jaw aches, headaches, migraines, neck or back pain)				
...behavioral issues at home or in school (attention, learning, hyper, sleepy, spectrum)				

Pediatric Sleep Questionnaire

(Screening)

Name of the child:_____________________________________ Date of birth:__________

Person completing this form: ____

Date that you are completing the questionnaire: _____________

Instructions: Please answer the questions about how your child **IN THE PAST MONTH**. Circle the correct response or *print* your answers in the space provided. "Y" means "yes," "N" means "no," and "DK" means "don't know." For this questionnaire, the word "usually" means "more than half the time" or "on more than half the nights."

Please answer the following questions as they pertain to your child in the past month.

		YES	NO	Don't Know
1.	**While sleeping, does your child:**			
	Snore more than half the time?	Y	N	DK
	Always snore?	Y	N	DK
	Snore loudly?	Y	N	DK
	Have "heavy" or loud breathing?	Y	N	DK
	Have trouble breathing, or struggle to breath?	Y	N	DK
2.	**Have you ever seen your child stop breathing during the night?**	Y	N	DK
3.	**Does your child:**			
	Tend to breathe through the mouth during the day?	Y	N	DK
	Have a dry mouth on waking up in the morning?	Y	N	DK
	Occasionally wet the bed?	Y	N	DK
4.	**Does your child:**			
	Wake up feeling unrefreshed in the morning?	Y	N	DK
	Have a problem with sleepiness during the day?	Y	N	DK
5.	**Has a teacher or other supervisor commented that your child appears sleepy during the day?**	Y	N	DK
6.	**Is it hard to wake your child up in the morning?**	Y	N	DK
7.	**Does your child wake up with headaches in the morning?**	Y	N	DK
8.	**Did your child stop growing at a normal rate at any time since birth?**	Y	N	DK
9.	**Is your child overweight?**	Y	N	DK
10.	**This child often:**			
	Does not seem to listen when spoken to directly..	Y	N	DK
	Has difficulty organizing tasks and activities...	Y	N	DK
	Is easily distracted by extraneous stimuli	Y	N	DK
	Fidgets with hands or feet, or squirms in seat	Y	N	DK
	Is "on the go" or often acts as if "driven by a motor"	Y	N	DK
	Interrupts or intrudes on others (eg butts into conversations or games)	Y	N	DK