Myofunctional Questionnaire:

Do you snore or breathe through your mouth at night?

YES NO

Have you been diagnosed with sleep apnea?

YES NO

Do you have any allergies or food sensitivities?

YES NO

Do you notice that you occasionally have your mouth open at rest or that you breathe through your mouth during the day?

YES NO

Do you feel chronically tired or fatigued even when you get enough sleep?

YES NO

Has anyone ever told you that you may be tongue-tied?

YES NO

Do you regularly experience any issues with digestion? (stomach pain, gas, bloating, acid reflux etc.)

YES NO

Have you had your tonsils and/or adenoids removed?

YES NO

Have you had any nasal or airway surgeries, or do you have a deviated septum?

YES NO

Do you have any jaw pain, facial pain, or headaches on a regular basis?

YES NO

Do you clench or grind your teeth, or wear a night guard?

YES NO