Respiratory and Myofunctional Questionnaire

(Ignore contact details if previously completed)

Family Name:	**Date:**	
Name:	**Age:**	
	DOB:	
Who referred you for the Assessment?		
What is the reason for your referral?		
Occupation:		
Address:	**Phone:**	
	Mob:	
Email:		
What sporting/exercise activities do you do?		
Describe your breathing		

Parents Health (asthma, sleep, illness etc.):						
Mother:						
Father:						
Medication:						
Intolerances/Sensitivities:						
Sugeries/Injuries:	**Year**					
	Natural	Caesarean	Induced	Forceps	Suction	Other
Birth:						
Breast feeding (how many years/months)						
Sleep/breathing/reflux/croup/illness to 18months						

Questionnaire

None or Rarely - You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

Occasionally - Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

Often - Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

Frequently - Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity.

Section 1 - Digestion:	**None/Rare**	**Occasional**	**Often**	**Frequently**
Do you suffer of constipation?				
Do you experience stomach cramping?				
Do you feel bloated?				
Do you experience excessive belching/flatulence?				
Do you experience gastric reflux?				
Irritable Bowel Syndrome?				
Section 2 - Sleep:	**None/Rare**	**Occasional**	**Often**	**Frequently**
Do you retire to bed after 10pm (adult); 8pm (child)?				
Do you sleep less than 8 hrs (adult); 10 hrs (child)?				
Does it take more than 10 mins to fall asleep?				
Does it take more than 30 mins to fall asleep?				
Do you experience sleep disturbance at night?				
Do you wake up at night?				
Do you have to go to the toilet at night?				
If you do wake, is it difficult to return to sleep?				
Do you notice your legs feel twitchy or jumpy when going to sleep?				
Notice wet patches on your pillow?				
Do you wake up with a bad taste in your mouth?				
Is your mouth dry/thirsty in the morning?				
Have you been heard to stop breathing at night?				
Have you ever awoken feeling like you're choking?				
Do you snore at night?				
Have you had a sleep study done?				
Have you been diagnosed with sleep apnea?				
Has a CPAP machine been suggested to you?				
Have you used a CPAP machine?				
Do you wake unrefreshed?				
Do you wake grumpy?				
Do you feel slow in the morning for more than 10 minutes?				
Do you wake with bad breath?				

Section 3 - Jaw/Teeth:	None/Rare	Occasional	Often	Frequently
Do you grind your teeth?				
Do you clench your teeth?				
Does you jaw click?				
Do you have jaw pain?				
Do you have neck stiffness?				
Section 4 - General:	**None/Rare**	**Occasional**	**Often**	**Frequently**
Do you have a constant runny nose?				
Do you find that your nose is often blocked?				
Do you have to clear your throat?				
Do you suffer of frequent colds?				
Cold hands and feet				
Retained fluid around hands and feet				
Allergies				
Hay Fever				
Sinusitis				
Anaemia				
Have you had pneumonia				
Smoking in the past?				
Currently smoking?				
Suffer of emphysema				
High Blood Pressure				
Low Blood Pressure				
Psoriasis				
Eczema				
Skin Dryness				
Itchy Flaky skin				
Do you sigh or yawn during the day?				
Poor energy levels				
Head aches				
Have you been diagnosed with asthma?				
Do you use asthma medication i.e Seretide or Ventolin?				
Have you had any facial injuries?				
Have you been in a motor vehicle accident?				
Have you suffered head injury(ies)?				
Do you exercise less than 3 times a week?				
Does your work involve sitting for more than 2 hours?				

Section 5 - Myofunctional:	**None/Rare**	**Occasional**	**Often**	**Frequently**
Do you notice your tongue sits in the bottom of your mouth?				
Do you notice that your tongue sits forward in your mouth (touching your teeth)?				
Do you feel that your tongue is too big for your mouth?				
Do you have trouble making some sounds?				
When you swallow, does it feel forced?				
When you swallow, can you see or feel your tongue push into your teeth?				
When you swallow, can you see or feel your tongue push out between your teeth?				
When you swallow, do you move your head				
Section 6 - Nervous System:	**None/Rare**	**Occasional**	**Often**	**Frequently**
Do you get irritated easily?				
Do you feel sad?				
Do you get frustrated easily?				
Do you get angry easily?				
Are you anxious or nervous?				
Do you find your home environment stressful?				
Do you find your work/school environment stressful?				
Do you suffer of poor concentration?				

Further notes:

PRACTIONER USE ONLY

Physical Assessment

Posture	Mild	Moderate	Severe	Total	
Forward Head Posture					
Posterior Cranial Rotation					
Upper Cervical Lordosis					
Lower Cervical Lordosis					C:
Thoracic Kyposis					T:
Decreased Lumbar Lordosis					L:
Increased Lumbar Lordosis					
Spinal Scoliosis					
Increased clavicular angle					
Abducted Scapulae					
Shoulders Medially Rotated					
Forearm pronation					
Hips	Sway=20	Ant=20	Post=20		
Knees Hyper Extended	Y=10	N=0			
Pronated Feet					
Supinated Feet					
Facial Structure					
Low Tongue Position					
Deviated septum					
Facial Structure					
Facial Symmetry					
Facial 3rds					
Venous Pooling					
Mandibular Tracking					
Intra oral Volume					
Turbinates Inflammed					
Nostril Size (L-R >10%)					
Nasal Tone					
Pharynx (thumb and index)					
Swallow					
Breathing Mechanics:					
Mouth Breathing					
Diaphragmatic Movement					
Rib movement Lateral					
Rib movement A/P					
Rib movement Vertical					
Rib Angle					
Scalene activity					
Increased Clavicular Angle					

	Optimal	Sub-Opt	Poor	Total	Number
Heart Rate					
Breath Hold out					
Breath Hold in					
Capnometry	Optimal	Sub-Opt	Poor	Total	ETCO2/BR
Base					
Self Relaxation					
Machine Guided					
Standing					
Challenges					