ARKANSAS OROFACIAL THERAPY

Get Started Guide

Orofacial Myofunctional Therapy

arkansasorofacialtherapy.com

WELCOME

Welcome to Arkansas Orofacial Therapy

We're so glad you're here.

Hello, and welcome! We're your care team at Arkansas Orofacial Therapy (AOT). We're thrilled you're here and would love to introduce you to the world of orofacial myofunctional therapy. Together, we'll uncover and work to correct any myofunctional impairments you may have, so you can move through life feeling and functioning at your best.

We created this guide to help you get set up with therapy and to share more about what the process looks like. We can't wait to get to know you and be part of your journey toward optimal wellness, health, and wellbeing.

ARKANSAS OROFACIAL THERAPY

> **Are you ready? Let's begin.**

Warmly,

Your Arkansas Orofacial Therapy Team
Info@aot.com

THE COMMITMENT

Expectations

Like anything in life, you get out what you put in — and 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. And if you go beyond what is asked, you'll 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 together.

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!

01

Show up ready

Come willing to put in the work — that's where results are made.

02

Practice between

Exercises build on each other. Consistency between sessions drives progress.

03

Support fully

Parents, be all in — you're an integral part of your child's success.

Let's get going!

WHERE TO START

Complete your Discovery Paperwork

Fully complete your paperwork and email it back to us at **Info@aot.com**. Print the appropriate pages and legibly fill them out. See the guide 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.

1. **Discovery Paperwork Checklist** everyone
   A checklist of history and symptoms we use to identify myofunctional impairment.
2. **Pittsburgh Sleep Quality Index** ages 18+
   Evaluates your sleep quality.
3. **Epworth Sleepiness Scale** ages 18+
   Evaluates your daytime sleepiness.
4. **Fatigue Severity Scale** ages 18+
   Evaluates the impact of fatigue on you.
5. **Sleep Hygiene Index** ages 18+
   Helps us plan sleep health promotion strategies.
6. **Quality of Life Scores** everyone
   Helps identify what you see as a problem.
7. **Pediatric Sleep Questionnaire** under 18
   Used to identify sleep concerns in children.

Submit as soon as you're done — in PDF format.

There are many free, simple apps that turn your phone into a scanner so you can scan and save as a PDF (we like Adobe Scan). This lets us file your paperwork correctly.

WHERE TO START

Connect & Learn More

Set up your video call

Your sessions happen over video. We'll send you a link to connect (Skype, Zoom, or your preferred platform) before your appointment. Please get set up ahead of time — better yet, test it out with a friend or family member first, so we don't waste any of your valuable appointment time on tech issues!

Not sure which platform to use? Just reach out to **Info@aot.com** and we'll help you get connected.

Learn more

Write down any questions and have them ready for your complimentary assessment or comprehensive exam!

Visit **arkansasorofacialtherapy.com** for more resources. On the following pages you'll find additional information about therapy packages, pricing, and other important topics you may find helpful.

YOUR ROADMAP

The AOT Process

1 STEP 1 Complimentary Assessment

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

2 STEP 2 Comprehensive Exam

- Discuss Discovery Paperwork & photos in more detail
- Discuss your therapy goals
- Breathing demonstration
- Functional assessment
- Choose your therapy package

3 STEP 3 Kit, Photos, Prepare

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

4 STEP 4 Phase 1 Therapy

- Frenectomy prep if needed
- Begin coordination, strength, proprioception & neuromuscular connections
- TMD work
- About 8 weeks

5 STEP 5 Comprehensive Therapy

- Snoring / Sleep Apnea
- Breath work
- Sleep health promotion
- Behavior modification
- Swallow & Eustachian tube dysfunction

Program duration

Depending on your chosen therapy program, duration is either **6 months** or **1 year**.

Preparation for a frenectomy (tongue-tie release) is about **8 weeks**.

INVESTMENT

Current Pricing

Payment due before beginning therapy. Payment plans and family discounts available.

ADULT THERAPY

Comprehensive

12 Months, 18 sessions

1:1, 30-minute sessions

$2,250

Phase 1

6 months, 10–12 sessions

1:1, 30-minute sessions

$1,550

YOUTH THERAPY

Comprehensive (9–18)

1 year, unlimited sessions

1:1, 30-minute sessions

$2,250

AOT Mini

AGES 4–8

1 year, unlimited sessions

1:1, 30-minute sessions

$1,225

During your comprehensive exam, we discuss which program is best for you based on your personality, learning style, and support needs. **Therapy plans are customized to each individual's needs and therapy goals.**

INTAKE · EVERYONE

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 us to communicate with your doctor? Yes / No

Dr. Name _____ **Dr. Email** _____

Where do you live? (Helps us know if we have a provider/partner in your area) _____

Infancy / Early Childhood

- ☐ Difficulty nursing or used a nipple shield
- ☐ Fell asleep while nursing or needed to nurse frequently
- ☐ Bottle-fed more than 50% of the time
- ☐ Had trouble with (or medicated for) reflux
- ☐ Colic symptoms, crying a lot, 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 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
- ☐ Rests with mouth closed, lips completely sealed
- ☐ Rests with mouth closed, lips MOSTLY sealed
- ☐ Rests with mouth open and lips open
- ☐ The lips are unable to close
- ☐ Other: _____

Digestive / Eating / Chewing / Swallowing

- ☐ Frequent digestive issues
- ☐ Reflux: unmedicated

- [ ] Reflux: medicated
- [ ] Bloating
- [ ] Burping
- [ ] Hiccupping
- [ ] Gas
- [ ] Constipation
- [ ] Slow, adequate chewing on BOTH sides
- [ ] Poor, quick chewing or chewing on one side
- [ ] Slow eating because eating is a chore
- [ ] Rapid eating because I'm in a hurry to swallow
- [ ] Tongue thrusts forward during swallowing
- [ ] Back of tongue doesn't lift during swallowing
- [ ] Difficulty 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

- [ ] 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 (not 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 back molars with tip of 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 (long-term, ongoing)
- [ ] Sharp and localized pain
- [ ] Pain on movement
- [ ] Pain reduced with rest
- [ ] Dull ache
- [ ] Diffuse (spread out) pain / 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 with mouth closed, lips sealed
- [ ] Occasional snoring
- [ ] Frequent snoring / loud breathing > 3 nights/week
- [ ] Loud snoring heard through a wall or door
- [ ] Anyone ever said 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? _____
- [ ] Prior sleep-disordered breathing dx, when/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?
- [ ] Male with a collar size > 17 inches?
- [ ] 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 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

List any current or past medical conditions and medications you take.

Who else is on your healthcare team?

Chiropractor, massage therapist, physical therapist, myofascial release, etc.

Any additional information

Anything else you would like us to know.

AGES 18+

Sleep Quality Assessment (PSQI)

Name _____ Date _____

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.

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? _____

4A. How many hours of actual sleep did you get at night? _____

4B. How many hours were you in bed? _____

5. During the past month, how often have you had trouble sleeping because you…

Reason	Not during 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. How often have you taken medicine (prescribed or over-the-counter) to help you sleep? _____

7. How often have you had trouble staying awake while driving, eating meals, or in social activity? _____

8. How much of a problem has it been to keep up enthusiasm to get things done? _____

9. How would you rate your sleep quality overall? (Very good 0 / Fairly good 1 / Fairly bad 2 / Very bad 3) _____

Scoring: A total score of 5 or greater is indicative of poor sleep quality. If you scored 5 or more, we suggest discussing your sleep habits with a healthcare provider.

AGES 18+

Epworth Sleepiness Scale (ESS)

Patient Name _____ **DOB** _____ **Date** _____

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 recently, think about how they would have affected you.

0 = would never doze **1 = slight chance** **2 = moderate chance** **3 = high chance**

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: Add the numbers in each box for your total score.

A total of less than 10 suggests you may not have excessive daytime sleepiness. A total of 10 or more suggests you may need further evaluation by a physician. This scale is a tool, not a diagnosis — please share your results and symptoms with your physician.

AGES 18+

Fatigue Severity Scale (FSS)

Patient Name _____ **DOB** _____ **Date** _____

Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week.

1 = strong disagreement **7 = strong agreement**

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: Add all the numbers you circled. A total of less than 36 suggests you may not be suffering from fatigue; 36 or more suggests you may need further evaluation by a physician. This scale is a tool, not a diagnosis.

AGES 18+

Sleep Hygiene Index (SHI)

Please rate how true each statement is for you by circling a number. Use the scale below.

0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Always

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 4 hrs 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 (video games, internet, cleaning).	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 (watch TV, read, eat, study).	0 1 2 3 4
10. I sleep on an uncomfortable bed (poor mattress or pillow, too much/little blanket).	0 1 2 3 4
11. I sleep in an uncomfortable bedroom (too bright, stuffy, hot, cold, or noisy).	0 1 2 3 4
12. I do important work before bedtime (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	

EVERYONE

Quality of Life Scores

These are common issues rated on a **1 (no problem)** to **10 (significant problem)** scale. Enter today's date at the top of a column, then rate each row based on your experience. You can track progress by scoring again on later dates.

I have trouble with...	Date	Date	Date	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, quick, drooling, tongue-tie)				
…sitting & standing with good posture (slouching, forward head, aches or pains)				
…eating & 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, wetting 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 school (attention, learning, hyper, sleepy, spectrum)				

UNDER 18

Pediatric Sleep Questionnaire

Name of child _____ **Date of birth** _____

Person completing this form _____

Please answer about your child in the past month. Circle the correct response. "Y" = yes, "N" = no, "DK" = don't know. "Usually" means "more than half the time" or "on more than half the nights."

Question	Yes / No / DK
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 breathe?	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 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 (butts into conversations or games)	Y N DK