VIBRANT
Myofunctional Therapy

YOU ARE IN THE RIGHT PLACE!

TOGETHER WE WILL WORK TO BRING YOU CLOSER TO THE HEALTHIEST AND MOST ENERGETIC PERSON YOU CAN BE!

Welcome!

Hi, I'm Amanda. I'm so glad you've made the decision to focus on your health and improve your energy levels. It's so important to take care of yourself and I'm always inspired by people who understand that we can't live our best life and help those around us if we don't make time for our own needs and health.

The first thing you need to do is fill out the forms on the next pages that apply to you. I will have a breakdown of what you need by age coming up.

You'll also want to make sure to get these back to me at least **two** days before your appointment. That way I have time to look them over.

They will give me a clearer picture of what you are struggling with and let me see if I can help you. After the exam I will come up with a treatment plan the focuses on you, and how to improve the symptoms that you are experiencing.

Now because I believe in being upfront and transparent I want you to understand that this will take a serious commitment from you. If we are working on therapy for your child I will need you to be very committed as it takes a lot of effort to make sure they are able to do the exercises and to remind them.

The more you work on the excercises and recommendations and fit them into your daily routine the better your results will be.

I promise you that I will be there throughout the whole process and as long as you are doing the work I will be just as committed in helping you achieve your therapy goals. I understand some of your struggles as I have experienced several myself. It is still a work in progress for me as well.

Anything we try that is new takes effort. But you are worth the effort and feeling better is worth the work, I promise you.

After you have filled out the forms please email them back to me as a **PDF** to
amanda@vibrantmyofunctionaltherapy.com
For the exam I will also need pictures and I have a section on that later as well.

We will meet virtually on Zoom. Please join the meeting at the time you have scheduled.

Also please write down any questions you have and I will go over them at the exam.

For the forms:

- **Pittsburgh Sleep Quality Index** (**ages 18+**) is the gold standard for evaluating **sleep quality**.
- **Epworth Sleepiness Scale** (**ages 18+**) is the gold standard for evaluating **daytime sleepiness**.
- **Quality of Life Scores** (**all ages**) is used to help us understand what you consider to be a problem.
- **Sleep Hygiene Index** (**ages 18+**) is used to help develop sleep health promotion strategies for you.
- **Pediatric Sleep Questionnaire** (**under 18**) is used to identify sleep concerns in children.

Once you have sent them back as PDF documents I can start working on your report. Thank you for sending them back at least 2 days early!

Let's Look At The Whole Process

ASSESSMENT (OPTIONAL)

This is a fast paced appointment where I look over your forms and see if I can help you. You will not need to send any of the photos. This is about 20-25 minutes and it helps us to see if we are a good fit and if we should move on to an exam to further discuss your symptoms and questions.

STEP 1

Comprehensive Exam

- Look at how your facial muscles are functioning
- See how your breathing looks.
- Define goals for therapy.
- After we are done I will chose a package that fits our treatment goals

STEP 2

Kit And Homework

- I will send your therapy kit!
- You will take a few more photos.
- Watch the getting started video

STEP 3

Begin Therapy: Phase 1

- Plan on 8 weeks if you need a frenectomy.
- Start to work on muscle coordination, strength, proprioception, and neuromuscular connection
- TMD

STEP 4

Phase 2 and 3 Therapy

- Work on breathing
- Snoring/ Sleep apnea
- Look at how we can improve your sleep
- Behavior modification
- Eustacian tube disfunction

THERAPY OPTIONS

ADULT THERAPY

Comprehensive 30 min 1:1

- 12 months 17 to 20 sessions
- $3500+
- Payment Plans available or $200 off if paid in full at time of accepting therapy

Phase 1 Therapy 30 min 1:1

- 6 months 10-12 sessions
- $3000+
- Payment plans available or $200 off if paid in full at time of accepting therapy

At your comprehensive exam we will be able to assess what plan will work best for you or your child. This is based on needs, time, learning style, and personality.

I want to make sure you have the best fit so your therapy can be successful and you can finally meet that vibrant and healthier version of you.

I am so excited for you to begin this journey and want you to know that I appreciate your trust.

Amanda J. Abrahamsen

YOUTH THERAPY

Youth Comprehensive 1:1

- 12 months long, 17-20 sessions
- The choice we want if your child is also struggling with behavioral issues.
- $3200+
- Payment plans available or $200 off if paid in full at time of accepting therapy

Mini Myo 1:1

- 12 months long, 10-12 sessions
- $2700+
- Payment plans available or $200 off if paid in full at time of accepting therapy

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.

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
1 = slight chance of dozing
2 = moderate 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.

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)				

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

Pediatric Sleep Questionnaire

(Screening)

Name of the child:_____ Date of birth:_____

Person completing this form: _____

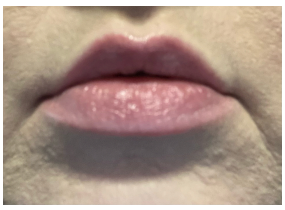
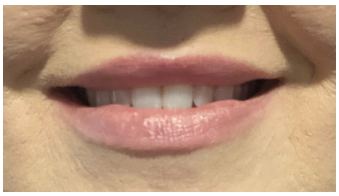
Date that you are completing the questionnaire: _____

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."

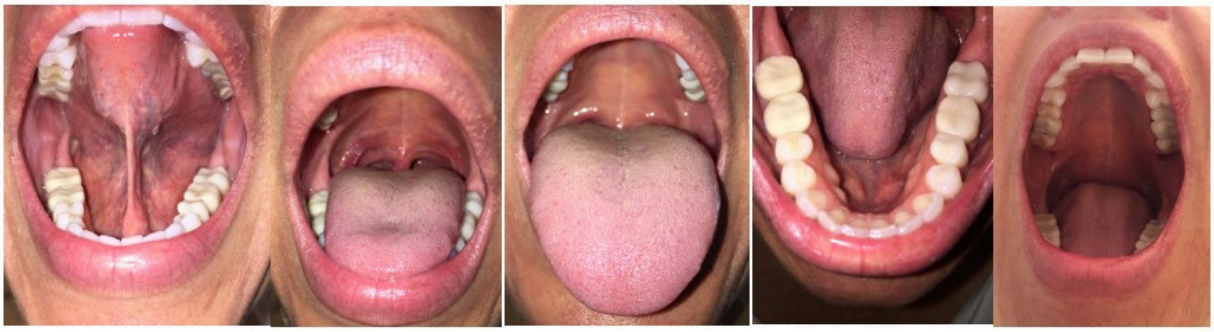
Please answer the following questions as they pertain to your child <u>in the past month</u>.

		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

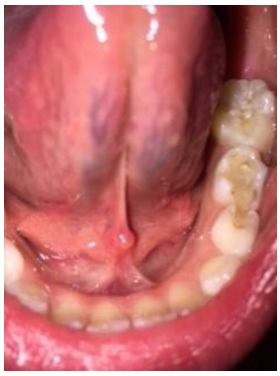
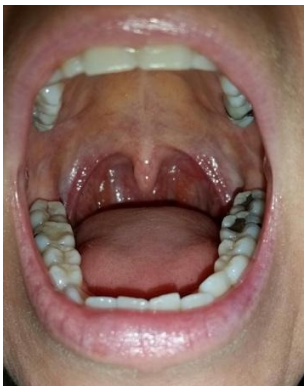


1. Front view with shoulders
2. Side profile showing full face and jawline
3. A picture of what YOUR mouth looks like when it is relaxed. This may be open or closed. Don't copy my mouth posture! Make sure you get an accurate photo of what YOUR resting mouth posture is!
4. Close up of your smile.



5. Open mouth wide and suction tongue up if possible. Be sure to get a clear photo of the underside of the tongue.
6. Open mouth naturally and show the back of the airway. Make sure tongue is **IN** the mouth and **DO NOT** say AHHHH. We are NOT attempting to look at the tonsils in this photo.
7. Open mouth wide and attempt to stick tongue STRAIGHT OUT. Then capture the photo showing what the tongue does when you are attemptng to stck it straight out.
8. Clear image showing bottom arch and all teeth.
9. Clear image showing the upper arch, palate and all teeth. You are showing me the shape of your palate in this photo, so please make sure the whole palate is visible.

10. This may take 2 photos to clearly show the needed information. I need to be able to see where the frenum attached onto the TONGUE (towards the free end of the tongue) AND I need to be able to see where it attaches in the FLOOR of the mouth. This photo example shows

both in one shot, so a second one wasn't needed. Please check the quality of your photo and make sure its adequate or send two different photos.

11. This picture needs to be a very clear photo of the TONSILS, or the TONSILAR area if they have been removed. This may take several tries, and it's important to use your flash. Make sure both tonsils are showing, or it's a clear picture of the area where they were!