VIBRANT
Myofunctional Therapy

Welcome to Vibrant Myofunctional Therapy
You're in the right place.

If you've been feeling tired, tense, or not quite like yourself, you're not alone. And you're not imagining it. Together, we'll uncover the habits and patterns that may be silently affecting your breathing, sleep, energy, and digestion.

Our work happens entirely on Zoom, designed to fit easily into your life. Weather you're looking for relief from jaw tension, help with mouth breathing, or just want to wake up feeling rested again, myofunctional therapy offers a holistic, evidence-based path forward.

This isn't just symptom management it's personalized care for your whole body, led with warmth, curiosity, and real strategy.

Your path to renewed vitality starts now. I'm so glad you're here.

vibrantmyofunctionaltherapy.com
amanda@vibrantmyofunctionaltherapy.com
Convenient virtual sessions on Zoom

Welcome.
Hi, I'm Amanda, your guide on this journey toward clearer breathing, deeper rest, and renewed energy.

Deciding to take care of yourself is a powerful step, especially when you've been running on empty for a while. You've likely spent so much time caring for others or pushing through discomfort that slowing down to focus on you may be unfamiliar.

But here's the truth: your body is wise. It's been sending signals for a reason. And now, we get to listen together with care, curiosity, and a practical plan forward.

Next Steps

1. **Complete the Forms:** Please fill out the forms on the following pages that apply to you. I'll provide a breakdown by age to guide you.
2. **Submit Forms Promptly:** Email the completed forms as PDFs to amanda@vibrantmyofunctionaltherapy.com at least two days before your appointment. This allows me time to review them thoroughly.
3. **Provide Photos:** For the Vibrant Airway Assessment and the Airway Clarity Intensive I will need specific photos. Detailed instructions are included in a later section.
4. **Prepare for Your Zoom Session:** We'll meed virtually on Zoom at your scheduled time. Please join the meeting promptly.
5. **Note Your Questions:** Write down any questions you have, and we'll go over them during the vibrant airway assessment or Airway Clarity Intensive.

Your Commitment Matters and So Does Mine

Starting this therapy is a meaningful investment in your health, and like any real change, it requires consistency and dedication.

The more you integrate the exercises and recommendations into your daily routine, the more progress you'll see and the more lasting your results will be. If we're working with your child, your involvement is just as essential to keep them on track and supported.

I'll be with you every step of the way. As long as you're doing the work, I'm fully committed to helping you reach your goals.

I've faced many of these same struggles myself, and I know how vulnerable it can feel to try something new. But I promise: you're worth the effort and feeling like your muscles are working to support you instead of having these silent dysfunctions draining you is worth the work.

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

A clear overview of how care typically unfolds, so you know what to expect.

Free Fit Call (Optional)

What it is:

A brief, no-pressure conversation to review your forms, answer initial questions, and help determine whether myofunctional therapy may be a good fit.

- Virtual
- 20-25 minutes
- No photos or videos required

Purpose:

To help you decide whether to move forward with an assessment or intensive.

Choose Your Starting Point

There are two ways to begin, depending on how much clarity you want upfront.

Option A

Vibrant Airway Assessment

Best for:

Those early in the process who want professional insight without a full intensive.

What we do:

- Review breathing patterns and oral posture
- Assess facial muscle function
- Discuss symptoms, goals, and history
- Identify whether therapy may be helpful

Outcome:

Clear recommendations and guidance on next steps.

Option B

Airway Clarity Intensive

Best for:

Those who want a comprehensive, one-time clinical review before deciding on ongoing care.

What we do:

- Review detailed intake forms, photos, and videos
- Evaluate airway function, tongue posture, breathing, and coordination
- Identify patterns contributing to fatigue, tension, or sleep issues
- Provide a written summary with findings and next-step options

If therapy is recommended, no additional assessment is required.

Ongoing Therapy Options

If therapy is appropriate and you choose to continue, we move into guided support.

Thrive+ Clarity

Phase 1 Therapy

- Preparation and coordination with providers when a frenectomy is indicated
- Focus on muscle coordination, strength, proprioception, and neuromuscular connection
- May include support for jaw tension or TMD

Thrive+ Integrative

Phase 2 and 3 Therapy

- Focus on breathing patterns and sleep support
- Support for snoring or sleep apnea (in collaboration with medical providers)
- Behavioral and habit-based retraining
- Support for Eustachian tube dysfunction when indicated

Not everyone needs every step.

Some clients complete an assessment or intensive and stop with clarity. Others benefit from ongoing support. The process is designed to meet you where you are and move at a pace that fits your life.

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)				

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

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 =_____

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
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.

Pediatric Sleep Questionnaire

(Screening)

Name of the child:_____ Date of birth:_____

Person completing this form: _____

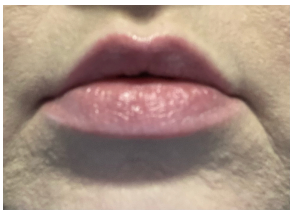
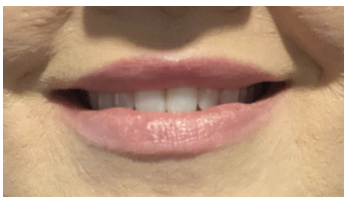
Date that you are completing the questionnaire: _____

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."

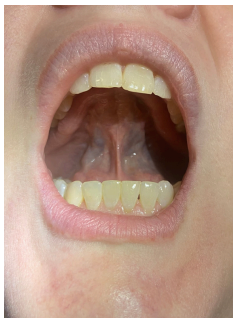
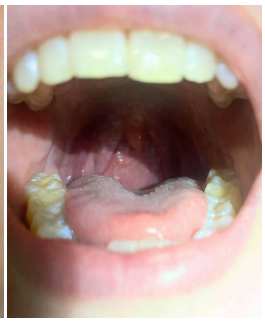
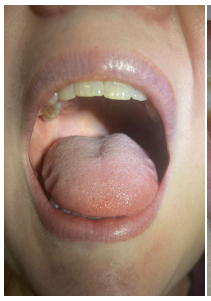
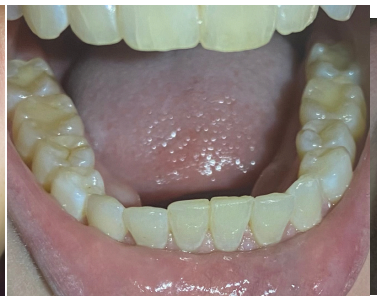
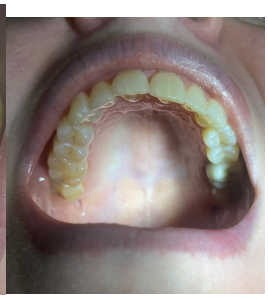
Please answer the following questions as they pertain to your child <u>in the past month</u>.

		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

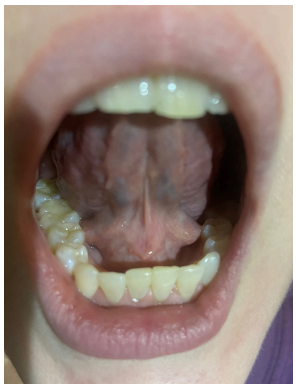
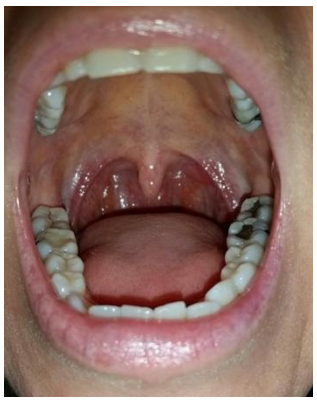


1. Front view with shoulders
2. Side profile showing full face and jawline
3. A picture of what YOUR mouth looks like when it is relaxed. This may be open or closed. Don't copy my mouth posture! Make sure you get an accurate photo of what YOUR resting mouth posture is!
4. Close up of your smile.

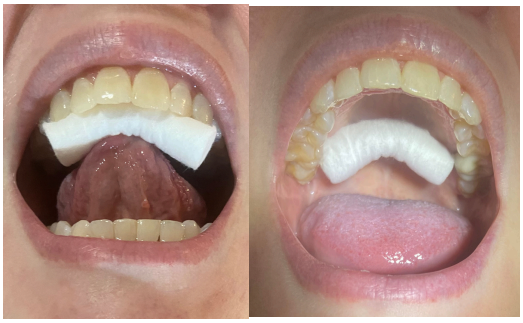
5. Open mouth wide and suction tongue up if possible. Be sure to get a clear photo of the underside of the tongue.
6. Open mouth naturally and show the back of the airway. Make sure tongue is **IN** the mouth and **DO NOT** say AHHHH. We are NOT attempting to look at the tonsils in this photo.
7. Open 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.

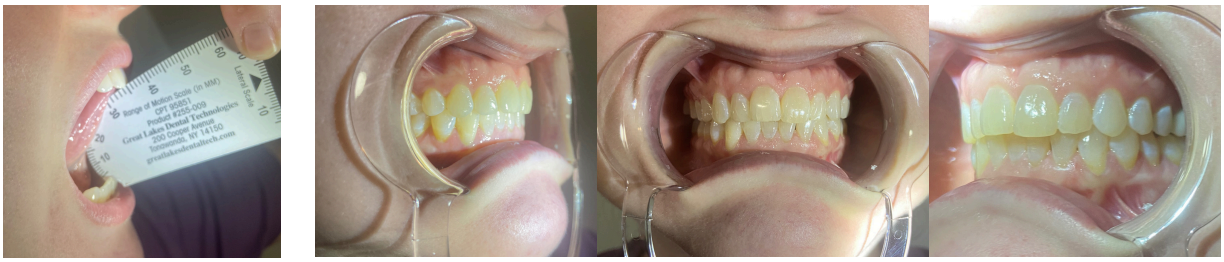
11. This picture needs to be a very clear photo of the TONSILS, or the TONSILAR area if they have been removed. This may take several tries, and it's important to use your flash. Make sure both tonsils are showing, or it's a clear picture of the area where they were!



12. Using the cotton roll, take a pictured of it placed at the tooth behind your canine (the long pointy corner tooth).

13. Using the cotton roll take a photo of it placed where your first molars are. This is your first large molar that is just behind the smaller premolars.

14. Take the range of motion scale (ROM) and take a clear picture of your mouth open as wide as possible with your tongue TOUCHING the roof of your mouth directly behind the top front teeth. Please do not suction while doing this. Just tough the tip of your tongue behind the upper front teeth. The tiny notch on the ROM scale will rest gently (it's pretty fragile and we will need to take a comparison picture at the end of therapy) on the lower teeth. Please make sure I can clearly see the measurements on the scale where your top front teeth are.



16-18. Use the cheek retractors in your kit. Take a clear picture of the bite from the R and L side and then one that shows you biting straight on.

19. Using cheek retractors take a video of 2 or 3 swallows so that I am able to check your swallowing pattern and look for tongue thrusting.

Additional Requirements For Youth Exams

1. Photo of youth sleeping
2. Full body photo against a solid-colored wall as a backdrop
3. Video of youth sleeping (long enough to capture any snoring or mouth breathing)
4. Video of youth telling a short story
5. Video of youth swallowing water
6. Video of youth chewing and swallowing a cracker or similar item

Additional Requirements For Adult Exams

1. Video drinking water
2. Video chewing and swallowing a cracker or similar item
3. Full body photo against a solid-colored wall as a backdrop