SYMPTOM TRACKER
Child

AOMT
ACADEMY of OROFACIAL MYOFUNCTIONAL THERAPY

Name: _____

Using the list of symptoms below, rate each one according to severity:

0 never - 1 rarely - 2 sometimes - 3 frequently - 4 always

SYMPTOMS:	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Blocked/ runny nose										
Dark circles under eyes										
Teeth grinding/clenching										
Waking up in the night										
Mouth breathing										
Dry mouth										
Bad breath										
Snoring										
Insomnia										
Many cavities										
Gingivitis										
Anxiety										
Difficulty concentrating										
Obstructive sleep apnea										
Toss & turn while asleep										
Sweaty hands/feet										
Fidgity										
Irritability										
Falling asleep during the day										
Exhausted on waking										
Lack of stamina										
Throat clearing										
Upper chest breathing										
Physical exhaustion										
TOTAL										
% CHANGE										