Child's Name:__________________________	**Age:**____________	**Gender:** ☐ Male ☐ Female

The following questions are about your child's night's sleep, morning awakening and daytime symptoms.

Getting to Sleep:

1. Who puts your child to sleep? ☐ Mother ☐ Father ☐ Sibling ☐ Self ☐ Other
   explain____
2. Child's sleep environment: ☐ Own bed/crib ☐ Other ☐ Firm mattress ☐ pillows
   describe____
3. Does your child sleep: ☐ alone ☐ With Mother ☐ with mother and father ☐ with siblings
   other____
4. How does your child fall asleep ☐ without help ☐ watching TV ☐ being rocked/held
   Other____
5. How long does it take for your child to fall asleep?_______________________________
6. If an infant, does your child sleep: ☐ on back ☐ on side ☐ on stomach
7. For an older child, sleep position of choice is: ☐ back ☐ side ☐ stomach

8. Is bedtime at a regular time nightly ☐ Yes ☐ No ☐ Variable
9. Is there a bedtime ritual ☐ nightly ☐ rarely ☐ never

10. Is your child put to bed awake? ☐ Yes ☐ No
11. Does your child report vivid dreamlike scenes before falling asleep? ☐ Yes ☐ No
12. Is your child fearful of going to sleep? ☐ Yes ☐ No
13. Does your child refuse to go to sleep? ☐ Yes ☐ No
14. Does your child repeatedly get out of bed once put into his/her room? ☐ Yes ☐ No
15. Insists on sleeping with a family member ☐ Yes ☐ No
16. Does your child drink caffeinated beverages before bed? ☐ Yes ☐ No
17. Does your child take medication in order to sleep ☐ Yes ☐ No
    list medication____
18. Does your child have a TV, computer, cell phone in his/her bedroom ☐ Yes ☐ No
    explain____

Please describe an average evening and an average bedtime routine:

____

____

During Sleep: Please comment on your child's behaviors during sleep

Sleep Symptoms	Nightly	Weekly	Monthly	Rarely	Never
Difficulty falling asleep?					
Difficulty staying asleep?					
Repeated awakenings					
Waking up too early					
Snoring or trouble breathing					
Chocking, gasping for air					
Morning headaches					
Sleeps in unusual positions					
Sleep walking					
Sleep talking					
Teeth grinding					
Nightmares					
Kick excessively during sleep					
Restless sleep					
Unpleasant feeling in arms or legs when lying down to sleep					
Describes urge to move legs at night when lying down to sleep					
Excessive sweating during sleep					
Labored breathing					
Scream out in sleep					
Bedwetting					
Excessive sweating in sleep					
Head bangs or rocks in sleep					
If awakens, has difficulty falling back to sleep?					
Mouth breather					
Drools excessively in sleep					
Has growing pains					
Anxious/panicky					
Appears to stop breathing during sleep					
Wakes up with burning sensation in chest					
Excessive hiccupping					

Comments:

____

____

____

____

Waking up: Please comment on your child's morning behaviors

Awakening Symptoms	Daily	Weekly	Monthly	Rarely	Never
Awakens unrefreshed					
Difficulty awakening					
Feels tired after sufficient sleep					
Morning headaches					
Temporarily unable to move					
Bed covers extremely messy					
Anxious or panicky feeling					
Appears well rested in the morning					
Moody, irritable on awakening					
Experience dreamlike scenes upon awakening					
Others:					

Daytime Symptoms	Daily	Weekly	Monthly	Rarely	Never
Tired during the day after a full night's sleep					
Struggling to stay awake					
Difficulty concentration					
Dozing off					
Trouble remembering					
Avoiding social situations					
Daytime sleepiness					
Sudden muscular weakness with strong emotion					
Feeling sleepy while driving					
Falling asleep in inappropriate situations					
Hyperactive, inattentive					
Difficulty focusing					
Have trouble at work or home because of sleep					
mood and behavioral difficulty					

***Sleep-Wake Schedule*: Schedules can vary from night to night. Do not worry about being exact, these are your best estimates and reflects your average day sleep wake schedule**

Does your child keep a fairly regular schedule ☐ Yes ☐ No

What time do you go to bed? Weekdays_______________ Weekends________________

What time do you get up? Weekdays________________Weekends_________________

Once in bed, how long does it take to fall asleep?_____________________________________

Once asleep, how many times does your child wakeup?_________________________________

If your child awakes during the night, how long to fall back to sleep:____

If an infant, how many hours during 24 hrs does he/she sleep?_____________________________

Do you awaken refreshed and ready to begin the day?____________________________________

Does your child nap during the day?

☐ A few days a week ☐ A few days a monthly ☐ Rarely/Never

Specify number of naps/day ____

If child naps, how long for each nap? ____

Are naps ☐ Yes ☐ No

When older child is able to choose own schedule (vacations, weekends) when does he/she prefer to go to sleep? ________________AM/PM.

When does he/she you prefer to wake-up______________________AM/PM

Many commonly used substances can affect sleep. Please describe your child's use of the following over the last month. Please list daily consumption.

Caffeinated beverages (tea, sodas, etc). ☐ Yes ☐ No

How much? __________________________________

How close to bedtime? ___________________________-

Non prescription, over the counter & other drugs. Please list ____________________________

____

____

Infant and Toddler Medical History: **(fill out this section if child is less than 3 years otherwise go to Past Medical History)**

Mother's Pregnancy

1. Did mother receive prenatal care? ☐ Yes ☐ No
2. Which trimester did prenatal care begin ☐ 1st ☐ 2nd ☐ 3rd
3. Did mother smoke during pregnancy? ☐ Yes ☐ No
4. Did father smoke in the house? ☐ Yes ☐ No
5. Did mother drink alcohol during pregnancy? ☐ Yes ☐ No
6. Did mother drink coffee during pregnancy? ☐ Yes ☐ No
7. Did mother take licit or illicit drugs during pregnancy? ☐ Yes ☐ No
8. List drugs or medications taken during pregnancy____
____
____
____
9. Where there any complications during pregnancy ☐ Yes ☐ No
Describe____
____
____
____
____
____

Delivery:

1. Infant's birth weight? ___________pounds ______________ounces
2. Infant's APGAR score? ______at I min _____at 5 minutes; Unknown
3. Was your child ☐ Term or ☐ Preterm
4. If pre-term how many weeks premature was your child? __________weeks
5. Was your child delivered ☐ Vaginally ☐ C-section ☐ Emergency
6. Did your child require resuscitation at birth? ☐ Yes ☐ No
7. If complications at birth? ☐ Yes ☐ No
describe____
____
____
____

Infancy:

1. Was your child ☐ breast feed ☐ formula fed
2. For how long ___________weeks ____________months ____________currently
3. Any problems with feeding (choking, coughing, turning blue)? Yes No
4. Does your child have difficulty gaining weight? ☐ Yes ☐ No
5. Has your child been diagnosed with reflux? ☐ Yes ☐ No
6. Any smoke exposure in the house or daycare? ☐ Yes ☐ No
7. Who smokes in the house? ☐ Mother ☐ Father ☐ grandparents ☐ care provider
8. Is your child on Oxygen" ☐ Yes ☐ No
9. If yes, for what reason?________________________________
10. Has your child been on a Home Apnea Monitor? ☐ Yes ☐ No
11. You child currently on a Home Apnea Monitor? ☐ Yes ☐ No
12. If yes, for what reason?___________________________________
13. Are there any concerns about your child's development? ☐ Yes ☐ No

    Explain____

    ____

Past Medical History: Has you child ever been diagnosed with (check any that apply).

☐ Asthma	☐ Allergies	☐ Colic	☐ Depression
☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Bronchitis
☐ Heart disease	☐ Lung Disease	☐ Liver Disease	☐ Reflux
☐ Kidney Disease	☐ Neurologic disease	☐ Seizure disorder	
☐ Immune disorder	☐ Psoriasis	☐ Hives	☐ Ecema
☐ Low thyroid	☐ High thyroid	☐ Arthritis	☐ Anemia
☐ Fibromyalgia	☐ Depression	☐ Chronic Sinusitis	☐ TB
☐ Anxiety/panic	☐ Migraines	☐ Bleeding disorder	
☐ Meningitis	☐ Learning difficulties	☐ Hyperactivity (ADD/ADHD)	
☐ Lactose intolerance			

Please describe if necessary or list any other health problems:____
____
____

Please list or describe any past surgeries or hospitalizations?____
____
____
____

Please describe any allergies, side effects or other adverse reactions to medications. If none, please write in "none":____
____
____
____
____

Please list the medications, vitamins, herbs and supplements your child may have taken in the last month. Please include both prescription and over-the-counter medications:

Medication	Dosage	Frequency	Reason	Date started

Medical Review of Symptoms: Check mark symptoms your child may be experiencing in the last few months.

Headaches		Shortness of breath		Chest pain	
Muscle pain		Nasal congestion		Blurred vision	
Double vision		Wheezing		Coughing	
Diarrhea		Constipation		Heart burn	
Skin problems		tremors		Incontinence	
Easy bleeding		Bruising		Frequent sore throats	
Heart palpitations		Urinary frequency		Difficulty swallowing	
Nose bleeds		Blood in stools		allergies	
Leg pain		Back pain		Stiffness	
Dizziness/fainting		Sinus trouble		Eye infections	
Abdominal pain		moodiness		Recent weight gain	
rashes		tremor		Easy bruising	
nausea		Loss of appetite		Head injury	

Child's Family Medical History:

Child's current family:

	Alive	**Deceased**
Mother		
Father		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

Siblings:

Male	Female	Alive	Deceased

Child's Family Medical History:

	Father	Mother	Siblings	Father's parents	Mother's parents	Aunts/uncles
Allergies						
Alcoholism						
Asthma						
Bleeding disorder						
Cancer						
Diabetes						
Glaucoma						
Epilepsy						
Heart Disease						
Heart attach						
Kidney Disease						
High Blood Pressure						
Mental illness						
Migraines						
Stoke						
Thyroid disease						
Restless Leg Syndrome						
Anemia						
Skin disease						

Others: Please indicate____

____

Does anyone in the family have the following sleep problems?

	Father	Mother	Siblings	Father's parents	Mother's parents	Aunts/Uncles
Sleep talking						
Bedwetting						
Needs sleep medication						
Narcolepsy						
Insomnia						
During the day muscles become weak with laughter						
Daytime sleepiness						
Sleep terrors						
Nightmares						
Snores						
Breathing pauses in sleep						
Sleep walking						

Please share any other concerns or information you feel important and relevant.____
____
____
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____