Patient Demographics

Today's Date:_____

Patient Name:_____ Date of Birth:_____ Age:_____

SS#_____ Male____ Female___ Marital Status: Married☐ Single☐ Other☐

Primary Address:_____

Mailing Address Or N/A: _____

Home Phone #_____ Work #_____

Cell Phone # _____ Email Address: _____

Patient Employer: _____ Occupation :_____

Spouse's Name:_____ Spouse DOB:_____

Spouse's Employer:_____ Spouse's Work # _____

Chief Complaint:_____

Referring Physician/Clinic:_____ Preferred Language:_____

Physician Phone # _____ Physician Fax #_____

Emergency Contact:_____ Phone: _____ Relation:_____

Primary Insurance Information

Insurance Company:_____Address:_____

Phone # _____ Fax # _____ Policy Holder:_____

Policy Holder's Date of Birth: _____ID # _____Group/ Policy #_____

Secondary Insurance Information

Insurance Company:_____Address:_____

Phone # _____ Fax # _____ Policy Holder:_____

Policy Holder's Date of Birth: _____ID # _____Group/ Policy #_____

Please Indicate the Following

Best Contact: Home☐ Work☐ Alt.☐ Email☐ Other_____ **May we leave a message**: Yes☐ No☐

Copy of HIPAA: Accept☐ Decline☐ **Copy of Patient Rights & Responsibilities:** Accept☐ Decline☐

ALLERGIES:

PEDIATRIC/ADOLESCENT SLEEP QUESTIONNAIRE

GENERAL SLEEP QUESTIONS

PATIENTS NAME: _____
PATIENTS AGE: _____ GRADE: _____
HEIGHT: _____ WEIGHT: _____

Do you feel that your child's sleep is abnormal? YES ☐ NO ☐
If YES, what is abnormal about your child's sleep? _____
_____
_____

At what age did this problem with sleep begin? _____

What time does your child usually go to bed? WEEKDAY: _____ WEEKEND: _____
Wake up? WEEKDAY: _____ WEEKEND: _____

Does your child have a bedtime routine? YES☐ NO ☐
If YES, what is it? _____
_____

Does your child have difficulty falling asleep? YES ☐ NO ☐
If YES, describe problem._____
_____

What is the total number of hours of sleep that your child usually gets at night? _____

Does he/she rest well when asleep? YES ☐ NO ☐

If NO, do they: have unusual movements during sleep? YES ☐ NO ☐
If YES, describe: _____

Suddenly wake up gasping for breath or unable to breathe? YES ☐ NO ☐

Bang his/her head on the bed or pillow during sleep? YES ☐ NO ☐

Hold his/her breath or stop breathing during sleep? YES ☐ NO ☐

How many times does your child wake up during a typical night's sleep? _____
Does your child wake from dreams? _____ How often? _____

Is your child difficult to wake up in the morning? YES☐ NO ☐
If YES, describe. _____
_____

Does your child have a problem with bed-wetting? _____ How often? _____

Does your child snore? YES ☐ NO ☐

At what age did this begin? _____

Can you hear him/her in another room? _____

Does your child still have their tonsils? YES ☐ NO ☐
If NO, When were they removed? _____

Does your child ever complain of headaches? YES ☐ NO ☐
If YES, What time of the day? _____

(Please ask your child's response to these next questions, if the child is old enough to respond).

How long does it usually take for your child to "get going" after he/she gets out of bed?
_____ hours _____ minutes

Does your child either fall asleep without intending to or have severe sleepiness without actually falling asleep? YES ☐ NO ☐

How many times a day does your child fall asleep? _____

Does your child fall asleep while: (please circle any that apply).

Eating ☐ Talking on the phone ☐ During a conversation ☐

In class ☐ Outside playing ☐ Watching TV ☐

How much of a problem does your child have with his/her school performance because of sleepiness?
_____
_____
_____

Is the child's sleep pattern the same on weekends? YES ☐ NO ☐
During summers and holidays? YES ☐ NO ☐
Does your child have vivid dreams during naps? YES ☐ NO ☐

Does your child ever feel unable to move while falling asleep or awakening? YES ☐ NO ☐

Does your child ever have a feeling of "weak knees" when laughing? YES ☐ NO ☐
If YES, How often? _____

Does your child ever have episodes of sudden muscular weakness or inability to move when laughing, angry, or in other emotional situations? YES ☐ NO ☐
If YES, Please describe:

_____
_____
_____
_____

Has your child ever had dream-like images (hallucinations) while awake? YES ☐ NO ☐

How often does your child have nightmares? (Please circle which applies)

Never ☐ sometimes ☐ frequently ☐

What time of the night do they occur? (Circle)

Early, right after going to sleep. ☐ Middle of the night. ☐ Just before awakening, in the morning. ☐

Are they violent? YES ☐ NO ☐

Can you wake the child during the nightmare? YES ☐ NO ☐

At what age did the nightmares start? _____

Does anything make them worse? _____
" " better? _____

Does your child have a full night of intense, vivid dreams? YES ☐ NO ☐

Does your child have a recurring dream that disturbs their sleep? YES ☐ NO ☐

Is your child on any medications? YES ☐ NO ☐
If YES, List them:

_____
_____
_____

Birth History: Child's weight: _____

Was your child full term? YES ☐ NO ☐
If No, How early was your child? _____

Were there any complications in your pregnancy? YES ☐ NO ☐
If YES, briefly describe: _____

Did your child have any problems immediately after birth? YES ☐ NO ☐
If YES, describe: _____

Has your child ever been hospitalized? YES ☐ NO ☐
If YES:

Date	Where	Reason

Has your child ever had surgery? YES ☐ NO ☐
If YES:

Date	Where	Type of surgery

Has your child had any other past medical problems? YES ☐ NO ☐
If YES, Please list them:

_____

_____

_____

Has anyone in your family had a problem with sleep disorders, seizure disorders, or emotional/psychiatric disorders? YES ☐ NO ☐
If YES:

Relationship to child	Type of disorder

Does your child have any allergies? YES ☐ NO ☐
If YES, Please list them:

_____
_____
_____

How much of the following fluids does your child drink?

	A day	Within 2 hrs. of going to bed	During the night
Coffee?	_____cups	_____cups	_____cups
Tea?	_____cups	_____cups	_____cups
Cola?	_____cups	_____cups	_____cups
Other?	_____cups	_____cups	_____cups

Is your child presently being followed by a physician for any specific problems? YES ☐ NO ☐
If YES, Please give the name of doctor and the problem being treated:

_____

_____

_____

_____

Who is your child's regular physician?

Name: _____

Address:_____

_____

Telephone number: _____

Use the area below to describe anything you feel we should know about your child. Please include any physical, emotional, and/or behavior problems.

_____

_____