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PSY 25438

Child Sleep Intake Form

Child's Name: _____ Sex: _____ Age: _____

Main sleep complaint(s) Is:

Sleep Pattern

	Weekdays	Weekends
Typical bedtime:	_____	_____
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that your child normally does during nighttime awakening(s), i.e., restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____	_____
Desired wake up time:	_____	_____
How does your child usually awaken, i.e., alarm clock, parent?:	_____	_____
Typical time your child gets out of bed:	_____	_____
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____
Times of naps per day: _____		

Please check all of the following statements that are true about your child's sleep:

Sleep Habits

- ☐ Usually watches TV or reads in bed prior to sleep
- ☐ Eats a snack at bedtime (If so, what? _____)
- ☐ Tantrums at bed time (If so, for how long? _____)
- ☐ Requires parent(s) in the room to fall asleep (at bedtime or night wakening)
- ☐ Gets out of bed at bed time (Does he/she return to bed? _____)
- ☐ Gets out of bed during the night (Does he/she return to bed? _____)
- ☐ Joins parent(s) in bed at bedtime or at night
- ☐ Eats if wakes up during the night
- ☐ Typically wakes up from sleep to go to the bathroom
- ☐ Has trouble falling asleep
- ☐ Often wakes up during the night

- ☐ Is unable to return to sleep easily if wakes up during the night
- ☐ Reports having thoughts that start racing through his/her mind when trying to fall asleep
- ☐ Wakes up early in the morning, and is still tired but unable to return to sleep
- ☐ Has nightmares
- ☐ Experiences a creeping-crawling or tingling sensation in legs when trying to fall asleep
- ☐ Sweats a great deal during sleep
- ☐ Cannot sleep on his/her back

Breathing

- ☐ Child stops breathing while sleeping
- ☐ Wakes up at night choking, smothering or gasping for air
- ☐ Snores
- ☐ Snores only when sleeping on his/her back

Restlessness

- ☐ Has uncomfortable feelings in his/her legs and/or arms when he/she lies down at night
- ☐ Has to move his/her legs or walk to relieve the uncomfortable feelings in his/her legs
- ☐ Is a restless sleeper
- ☐ Kicks or jerks legs and/or arms during sleep
- ☐ Has a hard time falling asleep because of his/her leg movements
- ☐ Talks in sleep
- ☐ Walks in sleep
- ☐ Grinds teeth in sleep
- ☐ Wets bed in sleep
- ☐ Has night terrors

Daytime Sleepiness

- ☐ Falls asleep while watching TV
- ☐ Falls asleep during conversations
- ☐ Falls asleep in sedentary situations
- ☐ Performs poorly in school because of sleepiness
- ☐ Has had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ☐ Drinks caffeinated beverages during the day: _____cups/bottles/cans per day

Social History

- ☐ Sleeps alone
- ☐ Share a bed with someone
- ☐ Shares a bedroom, but have separate beds

Medical History

Vital Statistics

Child's: Height? ____ feet _____inches
Weight? _____ pounds

Recent ☐ Weight loss ☐ Weight gain

Current Medications

Medication Name	How much?	How often?	Last taken?

Allergies:

_____

Past Sleep Evaluation and Treatment

- ☐ Has had a previous sleep disorder evaluation
- ☐ Has had a previous overnight sleep study
- ☐ Has had a daytime nap study
- ☐ Has been prescribed a CPAP or bilevel PAP machine for home use
- ☐ Has had surgical treatment for a sleep disorder
- ☐ Has previously been prescribed medication for a sleep disorder
- ☐ Has previously been treated for a sleep disorder

Past Medical History

- ☐ Hypertension (high blood pressure)
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Stomach or colon problems
- ☐ Lung problems/COPD/asthma
- ☐ Stroke
- ☐ Cancer
- ☐ Hepatitis/jaundice
- ☐ Hearing impairment
- ☐ Depression or severe anxiety
- ☐ Seizures
- ☐ Reflux
- ☐ Thyroid problems

List other past medical problems and dates:

Medical Problem	Date

List Surgeries and the year:

Surgeries	Year

Family History

Has an immediate blood relative had any of the following?

	Relation
☐ Anxiety/Depression	_____
☐ Sleep Apnea	_____
☐ Narcolepsy	_____
☐ Insomnia	_____
☐ Other: _____	_____