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PSY 25438

Infant Sleep Intake Form

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

Main sleep complaint(s) Is:

Sleep Pattern

Typical time start bedtime routine: _____
Bedtime routine: _____
Typical bedtime: _____
Is there anything required in the room for sleep? (night light, white noise, music, fan, etc.): _____
What does your child require in order to fall asleep (bottle, rocking, singing, pacifier, blankie, etc.): _____
Room and where your baby usually sleeps (ex: bedroom and crib): _____
Typical amount of time it takes to fall asleep: _____
Baby sleeps on his/her ☐ Back ☐ Stomach ☐ Side
Typical number and time of awakenings per night: _____
List any activities that your infant normally does during nighttime awakening(s), i.e., feeds, plays, screams, rocking, etc.: _____
Typical amount of time to fall back asleep after an awakening: _____
Typical wake up time: _____
Desired wake up time: _____
Typical time your baby gets out of crib: _____
Total amount of sleep per night: _____
Number of naps per day: _____
Times and length of naps per day: _____
Routine for naptime: _____
Do you have any of the following in the crib (check all that apply)?

☐ Bumpers ☐ Pillows ☐ Blankets
☐ Toys ☐ Stuffed animals ☐ Pacifiers
☐ Bottle ☐ Mobile ☐ Light/sound activity
☐ Security blankie

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

Sleep Habits

☐ Usually watches TV or plays in bed prior to sleep
☐ Eats to fall asleep

☐ Requires parent(s) in the room to fall asleep (at bedtime or night wakening)
☐ Joins parent(s) in bed at bedtime or at night
☐ Eats if wakes up during the night
☐ Throws up in crib
☐ Has a bowel movement at bedtime or naptime or during the night
☐ Often wakes up during the night
☐ Cannot put pacifier in if it falls out
☐ Is unable to return to sleep easily if wakes up during the night
☐ Wakes up early in the morning, and is still tired but unable to return to sleep

Breathing
☐ Snores
☐ Snores only when sleeping on his/her back

What have you tried to address your concerns?

_____
_____
_____
_____

Medical History

Developmental Milestones

Milestone	Age Reached	Can do independently	Can do with assistance
Rolling over			
Sitting up			
Eating solids			
Scooting			
Crawling			
Eating finger foods			
Standing up			
Walking			
First Words			
Sentences			

Currently Breast-fed or Bottle-fed? _____

Vital Statistics
Baby's: Height? _____inches
Weight? _____ pounds

Current Medications

Medication Name	How much?	How often?	Last taken?

Allergies:

_____

Medical History

☐ Difficulties with weight gain
☐ Acid reflux
☐ Lung problems/asthma
☐ Jaundice
☐ Seizures

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: _____	_____