

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female

Child's date of birth (month/day/year): \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Race: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Person completing this questionnaire: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Daytime Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Evening Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Mother's Age: \_\_\_\_ Occupation: \_\_\_\_\_ Father's Age: \_\_\_\_ Occupation: \_\_\_\_\_

**Please list who takes care of the child. Include their name, relationship and time of day and night that they give care:** \_\_\_\_\_  
\_\_\_\_\_

**Please describe your child's sleep problem(s) including both nighttime and next day symptoms:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How long have they had these problems ?** \_\_\_\_\_

**Goals of treatment:** (please circle all that apply)

- |  |   |
|--|---|
| Changing bedtime (earlier or later)      | Child goes to bed without fussing/crying/stalling |
| Child sleeps in their own bed            | Having your child sleep through the night         |
| Better breathing during the night        | More restful sleep (quieter, less movement)       |
| Changing wake up time (earlier or later) | Better attention and/or mood during the day       |

**Please describe any past professional evaluations or treatments for your child's sleep problems, including what was and was not helpful?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What have you tried on you own to improve your child's sleep and was it helpful?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When your child sleeps how often do you observe the following:	Daily	Weekly	Monthly	Rarely	Never
Difficulty <i>falling</i> asleep?					
Trouble <i>staying</i> asleep?					
Repeated awakenings?					
Waking up <i>too early</i> ?					
Snoring or loud breathing?					
Choking or gasping for air?					
Pauses in breathing or breathing stop?					
Labored breathing?					
Leg, arm or body jerks?					
Crying or moaning noises but still asleep?					
Sleep talk?					
Sleep walk?					
Grind their teeth?					
Have nightmares?					
Leave their bed during the night?					
Wet the bed?					
Other unusual behaviors? Please describe:					

**Please answer these questions for the last month:** Do not worry about being exact, these are just estimates.

**Did your child have a fairly regular schedule?** Yes      No

**What activities (eating, reading, watching TV, taking a bath etc.) does your child do during the 30 minutes before their night bedtime:** \_\_\_\_\_

**List the people that put the child to bed?** \_\_\_\_\_

**Typical bedtime** \_\_\_\_\_ AM/PM. **Earliest bedtime** \_\_\_\_\_ AM/PM. **Latest bedtime** \_\_\_\_\_ AM/PM.

**Time to fall asleep (in minutes)?** Typical \_\_\_\_\_. Shortest \_\_\_\_\_. Longest \_\_\_\_\_.

**Once asleep, how many awakenings?** Typical \_\_\_\_\_. Fewest \_\_\_\_\_. Most \_\_\_\_\_.

**How much lost sleep from awakenings (in minutes)?** Typical \_\_\_\_\_. Least \_\_\_\_\_. Most \_\_\_\_\_.

**Number of hours of sleep at night?** Average \_\_\_\_\_. Least \_\_\_\_\_. Most \_\_\_\_\_.

**Typical wake-up time** \_\_\_\_\_ AM/PM. **Earliest** \_\_\_\_\_ AM/PM. **Latest** \_\_\_\_\_ AM/PM.

**How many mornings a week did someone have to wake the child up?** \_\_\_\_\_

**How often did your child take a scheduled nap?** Daily      A few days a week      Rarely/Never

**When were they most likely to take a nap(s)?** \_\_\_\_\_ AM/PM.

**Length of daytime naps (in minutes)?** Average \_\_\_\_\_. Shortest \_\_\_\_\_. Longest \_\_\_\_\_.

**Did your child fall asleep unplanned (i.e. driving in the car)?** Daily      A few days a week      Rarely

**Diet/Nutrition**

Does your child eat solid foods?      Yes      No

Is your child a finicky eater?      Yes      No

Does your child have regular meal times?      Yes      No

When do they eat breakfast? Typical \_\_\_\_\_ AM/PM. Earliest \_\_\_\_\_ AM/PM. Latest \_\_\_\_\_ AM/PM

When do they eat lunch?      Typical \_\_\_\_\_ AM/PM. Earliest \_\_\_\_\_ AM/PM. Latest \_\_\_\_\_ AM/PM

When do they eat dinner?      Typical \_\_\_\_\_ AM/PM. Earliest \_\_\_\_\_ AM/PM. Latest \_\_\_\_\_ AM/PM

Does your child have snacks after dinner?      Always      Sometimes      Rarely/Never

Does your child go to sleep with a bottle      Always      Sometimes      Rarely/Never

**Nighttime Sleeping Environment**

Does your child sleep in their own room?      Nightly      A few times a week      Rarely/Never

Does your child ever share a bed?      Nightly      A few times a week      Rarely/Never

Does your child sleep with a pet in the room?      Nightly      A few times a week      Rarely/Never

When asleep at night what are the sources of light in your child's room (night light, open door, none): \_\_\_\_\_.

What are the sources of noise in your child's room (street noise, other children, T.V.): \_\_\_\_\_.

\_\_\_\_\_.

Over the course of the last month please list where your child slept during the night: \_\_\_\_\_.

\_\_\_\_\_.

How often do people smoke in the house?      Daily      A few days a week      Rarely      Never

**Family Sleep and Medical History**

Please list blood relatives (parents, siblings, grand parents etc.) who snore, have daytime sleepiness, insomnia or other sleep disorders: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list blood relatives with medical or psychiatric disorders: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Development History

Please list any complications during your child's pregnancy and/or delivery? \_\_\_\_\_

How much did your child weight at birth? \_\_\_\_\_

How much did your child weight at their last doctors appointment? \_\_\_\_\_

Has there ever been any concern about your child's growth    Yes        No

Is your child potty-trained?    Yes        No

### General Medical History

**Has your child ever been diagnosed with (check any that apply):**

- |                    |                           |                 |
|--------------------|---------------------------|-----------------|
| Ear infections     | Sinus infections          | Diabetes        |
| Heart disease      | Lung disease              | Liver disease   |
| Kidney disease     | Head trauma or concussion | Thyroid disease |
| Neurologic disease | Psychiatric disorder      | ADHD            |
| Learning disorder  | Behavior disorder         | Seizures        |

**Please list any other health problems:** \_\_\_\_\_

**Please list the names of your child's healthcare providers** (If possible include the city where they practice) \_\_\_\_\_

**Please describe any past surgeries or hospitalizations your child has had:** \_\_\_\_\_

Please list the medications, vitamins, herbs, and supplements that your child has taken in the last month. Please include both prescription and over-the-counter medications:				
Medication	Dosage	Frequency	Reason	Date started

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

**We are located in the HM Poole Medical Office Building  
Scripps Memorial Hospital Campus, La Jolla**

### Driving Directions

#### From North County:

1. Take I-5 South to Genesee Avenue Exit.
2. At off ramp signal, turn LEFT (East).
3. Go to first traffic light (after passing freeway), TURN RIGHT into Scripps Hospital campus.  
SEE PARKING DIRECTIONS BELOW.

#### From Greater San Diego

1. Take I-5 North to Genesee Avenue Exit.
2. At off ramp follow curve to the RIGHT (heading East on Genesee Avenue).
3. Go to first traffic light, TURN RIGHT into Scripps Hospital campus.  
SEE PARKING DIRECTIONS BELOW.

#### From Interstate-805:

1. Take Miramar Road/La Jolla Village Drive Exit. Head West on La Jolla Village Drive.
2. TURN RIGHT onto Genesee Avenue.
3. Go one-mile (through several traffic lights).
4. Turn LEFT at signal into Scripps Hospital campus.  
SEE PARKING DIRECTIONS BELOW.

### Parking Directions

After entering the Scripps Campus drive to the parking gate and get a ticket.  
At **SECOND** stop sign **turn RIGHT**. After two more stop signs (3rd & 4th),  
you will see our 4-story building on the **RIGHT**:  
**"9834" HM Poole Medical Office Building.**  
Parking Structure is to your **LEFT**.

Parking Fee is \$3 with ticket validation from our office.

#### POOLE BUILDING

Directly across the street from the parking structure is the entrance to the Poole Building. Upon entering you will be on the Lobby Level (second floor). Our office is on the first floor, in Suite 112.

#### ELEVATOR

Take the elevator to Level 1.  
Exit elevator **TURN LEFT**. Suite 112 is the first door on the right.

Please allow 5-minutes to park and walk to our office.

