TMJ & Sleep Therapy Centre

PEDIATRIC HEALTH QUESTIONNAIRE

This questionnaire has been compiled from multiple sources to best help us assess a pediatric patient's sleep. Please fill out all questions to the best of your knowledge. This information will become part of the medical record and is considered confidential.

Today's Date: _____

Child Demographic Information

☐ Male ☐ Female

Last Name: _____ Middle Initial: _____ First Name: _____ Gender:

Date of Birth: _____ Age: _____ School Grade: _____ Height: _____ ft _____ in Weight: _____ lbs

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Contact Information

Parent/Guardian Full Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Referral Information - how did you hear about us?

Referral Name/Source: _____

Referral Type: ☐ Doctor ☐ Dentist ☐ Specialist ☐ Patient ☐ Other _____

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

☐ I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Daniel G. Klauer, DDS including a full report of examination findings, diagnosis, treatment plan and progress report between TMJ & Sleep Therapy Centre and the professional care team listed above.

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

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Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

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Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

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1245 E. University Drive
Granger, IN 46530

Allergy Information

Is your child allergic to any medications? ☐ Yes ☐ No If yes, which medications? _____

_____

_____

Does your child have any environmental allergies? ☐ Yes ☐ No If yes, please explain: _____

_____

Reason for Appointment

What results are you seeking from treatment? _____

_____

Pain and/or Jaw Symptoms

Is your child experiencing any pain? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Sleep Symptoms

What are your major concerns about your child's sleep?

_____

_____

What have you previously tried to help this problem?

_____

_____

Sleep Times

Total estimated amount of sleep on a weekday (this includes naps): _____ hours _____ minutes

Usual bedtime on weekday nights: _____ P.M. Usual waketime on weekday mornings: _____ A.M.

Total estimated amount of sleep on a weekend day (this includes naps): _____ hours _____ minutes

Usual bedtime on weekend nights: _____ P.M. Usual waketime on weekend mornings: _____ A.M.

Is there a difference between weekdays and weekends? _____

Why? _____

_____

Nap Times

Number of days each week on average that your child takes a nap: _____ days

Nap Times (on average): Start: _____ A.M./P.M. End: _____ A.M./P.M.

Family History

Mother Age: _____ Education Level: _____ Occupation: _____

Father Age: _____ Education Level: _____ Occupation: _____

Other persons living in the home and relationship: _____

Does anyone have a sleep disorder? ☐ Yes ☐ No Who? _____

Disorder: _____ Date Diagnosed: _____

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Past Medical History

Pregnancy: ☐ Normal ☐ Difficult

Delivery: ☐ Term ☐ Pre-Term ☐ Post-Term

Child's Birth Length: _____ ft _____ in

Child's Birth Weight: _____

Feeding: ☐ Breastfed ☐ Bottle

Until Age: _____

Is he/she an only child? ☐ Yes ☐ No

If no, what number child is this one? _____

Birthing Notes: _____

Child's Medical History

	Yes	No	Don't Know
Frequent nasal congestion?	☐	☐	☐
Does the child Trouble breathing through his/her nose?	☐	☐	☐
Sinus problems?	☐	☐	☐
Chronic bronchitis or cough?	☐	☐	☐
Environmental allergies?	☐	☐	☐
Asthma?	☐	☐	☐
Frequent colds or flus?	☐	☐	☐
Frequent ear infections?	☐	☐	☐
Frequent strep throat infections?	☐	☐	☐
Difficulty swallowing?	☐	☐	☐
Acid reflux (gastroesophageal reflux)?	☐	☐	☐
Poor or delayed growth?	☐	☐	☐
Excessive weight?	☐	☐	☐
Hearing problems?	☐	☐	☐
Speech problems?	☐	☐	☐
Vision problems?	☐	☐	☐
Seizures/Epilepsy?	☐	☐	☐
Morning headaches?	☐	☐	☐
Cerebral palsy?	☐	☐	☐
Heart disease?	☐	☐	☐
High blood pressure?	☐	☐	☐
Sickle cell disease?	☐	☐	☐
Genetic disease?	☐	☐	☐
Chromosome problem (e.g., Down's Syndrome)?	☐	☐	☐
Skeleton problem (e.g., dwarfism)?	☐	☐	☐
Craniofacial disorder (e.g., Pierre-Robin)?	☐	☐	☐
Thyroid problem?	☐	☐	☐
Eczema (itchy skin)?	☐	☐	☐
Pain?	☐	☐	☐

Other Information: _____

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General Sleep Information	Yes	No	Don't Know
Does your child have a regular bedtime?	☐	☐	☐
Does the child have his/her own bedtime?	☐	☐	☐
Does the child have his/her own bed?	☐	☐	☐
Is there a parent present when the child falls asleep?	☐	☐	☐
Does the child have difficulty falling asleep?	☐	☐	☐
Does the child awaken during the night?	☐	☐	☐
If awakening at night, does the child have difficulty returning to sleep?	☐	☐	☐
Is the child a poor sleeper?	☐	☐	☐
Does the child alternate between households? If yes, please explain. _____	☐	☐	☐

Current Sleep Symptoms	Never	Occasionally	Frequently	Don't Know
Difficulty breathing when asleep?	☐	☐	☐	☐
Stops breathing during sleep?	☐	☐	☐	☐
Snores?	☐	☐	☐	☐
Restless Sleep?	☐	☐	☐	☐
Sweating when sleeping?	☐	☐	☐	☐
Poor appetite?	☐	☐	☐	☐
Nightmares?	☐	☐	☐	☐
Sleepwalking?	☐	☐	☐	☐
Sleep talking?	☐	☐	☐	☐
Screaming during sleep?	☐	☐	☐	☐
Leg kicking during sleep?	☐	☐	☐	☐
Waking up at night?	☐	☐	☐	☐
Getting out of bed at night?	☐	☐	☐	☐
Trouble staying in his/her bed?	☐	☐	☐	☐
Resistance going to bed?	☐	☐	☐	☐
Teeth grinding?	☐	☐	☐	☐
Uncomfortable "creepy-crawly" feeling in his/her leg?	☐	☐	☐	☐
Bed wetting?	☐	☐	☐	☐

Current Daytime Symptoms	Never	Occasionally	Frequently	Don't Know
Trouble getting up in the morning?	☐	☐	☐	☐
Falls asleep at school?	☐	☐	☐	☐
Naps after school?	☐	☐	☐	☐
Daytime sleepiness?	☐	☐	☐	☐
Feels weak or loses control of his/her muscles with strong emotions?	☐	☐	☐	☐
Reports being unable to move when falling asleep or upon wakening?	☐	☐	☐	☐
Reports frightening visual images before falling asleep or upon waking?	☐	☐	☐	☐

Additional Symptoms Noticed: _____

Patient/Guardian Initials: _____

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Past Psychiatric History	Yes	No	Don't Know
Noxious habits (thumb sucking, pacifier use)?	☐	☐	☐
Autism?	☐	☐	☐
Developmental delay?	☐	☐	☐
Hyperactivity/ADHD?	☐	☐	☐
Anxiety/Panic attacks?	☐	☐	☐
Obsessive compulsive disorders?	☐	☐	☐
Depression?	☐	☐	☐
Learning disabilities?	☐	☐	☐
Drug use/abuse?	☐	☐	☐
Behavioral disorder?	☐	☐	☐
Psychiatric admission?	☐	☐	☐
Emotional/Sexual/Physical/Verbal abuse?	☐	☐	☐

Past Surgical History

Has your child ever had his/her tonsils removed? ☐ Yes ☐ No At what age? _____

Has your child ever had his/her adenoids removed? ☐ Yes ☐ No At what age? _____

Has your child ever had ear tubes? ☐ Yes ☐ No At what age? _____

What other surgeries has your child had (include age when surgery performed)?

_____

_____

What other treatments has your child had (include age when treatment performed)?

_____

_____

Medications

Name of Medication	Reason	Dose	Frequency

Additional Information to Note

_____

_____

_____

Signature

☐ I acknowledge that I have been offered a copy of the Office Privacy Notice and I am familiar with my rights as a patient of Dr. Klauer and TMJ & Sleep Therapy Centre

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Printed Name Patient Printed Name