TMJ & Sleep
Therapy Centre

Pediatric Sleep Evaluation 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

Last Name: _____ Middle Initial: ____ First Name: _____ Gender: ☐ Male ☐ Female

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

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Parent Contact Information

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

Home/Cell Phone: _____ Work Phone: _____

Email: _____

Provider Information

Referral Source: _____

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

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

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

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

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Patient/Guardian Initials: _____

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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? _____

Sleep Problems

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 wake time on weekday mornings: _____

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

Usual bedtime on weekend nights: _____ P.M. Usual wake time on weekend mornings: _____

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.

Patient/Guardian Initials: _____

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Family History

Mother Age: _____ Education Level: _____ Occupation: _____

Father Age: _____ Education Level: _____ Occupation: _____

Other persons living in the home and relationship: _____

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

Disorder: _____ Date Diagnosed: _____

Past Medical History

Pregnancy: ☐ Normal ☐ Difficult Delivery: ☐ Term ☐ Pre-Term ☐ Post-Term

Child's Birth Weight: _____ lbs. _____ oz. Child's Birth Length: _____

Feeding: ☐ Breastfed ☐ Bottle Until Age: _____ year(s) _____ months

Is he/she an only child? ☐ Yes ☐ No If no, what number child is this one? _____

Birthing Notes: _____

Child's Medical History

	Yes	No
Frequent nasal congestion?	☐	☐
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: _____

Patient/Guardian Initials: _____

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General Sleep Information

	Yes	No
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
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
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
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 agree, the above information is accurate and complete to the best of my knowledge.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____ Patient Printed Name _____