34474-08

Children's Physician Group
Sleep

INTAKE FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Dear Parent:
Thank you for allowing us to care for your child. If you are receiving this form via email or mail, please complete it before your visit. If you have received this form on the day of your visit, please complete this form as you wait and let registration know once you are finished.

Please check all that apply when answering the questions below: **SLEEP SCHEDULE**

School or Weeknight

1. Usual bedtime on school or weeknight _____
2. Average duration (length of time) to fall asleep _____
3. Usual wake up time on school or weekday _____

Weekend

1. Usual bedtime on weekend _____
2. Average duration (length of time) to fall asleep _____
3. Usual wake up time on weekend _____

Naps

1. Does the child nap?
   □ Yes □ No
2. What days does the child nap? (choose all that apply)
   □ Sunday □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday
3. Nap time _____
4. Average duration of nap (choose only one)
   □ 10 minute □ 20 minutes □ 30 minutes □ 40 minutes □ 50 minutes □ 60 minutes □ 2 hours
   □ 3 hours □ 4 hours

SLEEP ENVIRONMENT/HABITS

1. Child has his/her own (choose only one)
   □ Bedroom □ Bed
2. Items that remain on in room while child sleeps (choose only one)
   □ Room light □ Night light □ TV □ Music □ Fan
3. Items in bed with child at bedtime (choose all that apply)
   □ Cell Phone □ Tablet □ laptop □ Videogames □ Toys □ Bottle/Sippy cup

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4. Servings of 8 oz. of caffeine per day (choose only one)
   □ Never □ 1-2 servings □ 3-4 servings □ 5-6 servings □ >6 servings

NIGHT TIME SYMPTOMS

Difficulty with Sleep

1. At bedtime, the child: (choose all that apply)
   □ Has difficulty falling asleep □ Needs a parent present to fall asleep
   □ Needs to be rocked, patted or held to fall asleep □ Is transferred to his/her bed after falling asleep

2. In the middle of the night, the child (choose all that apply)
   □ Does not wake up □ Wakes up nightly □ Wakes 1-2 times per night □ Wakes 3-4 times per night
   □ Wakes 5-6 times per night □ Wakes > 8 times per night □ Wakes 1-2 times per week
   □ Wakes 3-4 times per week □ Wakes 5-6 times per week □ Needs a parent present to fall back to sleep
   □ Needs to be rocked, patted or held to fall back to sleep Takes □ 10 min □ 30 min □ 60 min to fall back to sleep □ Never falls back to sleep

Breathing in Sleep

1. During sleep, the child:
   □ Snores □ Stops breathing □ Grunts/chokes/snorts □ Sweats □ Restless sleep □ Has difficulty breathing □ Sleeps with his/her neck hyperextended □ Prefers to sit up to sleep

Complex Behaviors in Sleep

1. During sleep, the child (choose all that apply)
   □ Bed wets □ Sleepwalks □ Sleep talks □ Screams out □ Grinds teeth □ Nightmares
   □ Vivid dreams □ Appears to act dreams out

Sleep Related Movements

1. As the child falls asleep, he/she (choose all that apply)
   □ Head bangs □ Body rocks

2. Complains of an uncomfortable feeling in his / her legs
   □ If yes ⟶ (choose all that apply)
   - □ Has an urge to move his/her legs
   - □ The uncomfortable feeling occur at night
   - □ The uncomfortable feeling occur at rest (i.e. sitting or lying down)
   - □ The uncomfortable feeling improve with movement

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DAY TIME SYMPTOMS

1. The child has (choose all that apply)
   □ unrefreshing sleep □ has morning headaches □ has difficulty waking in the morning
   □ dozes off at school □ sleeps after school □ complains of feeling sleepy during the day
   □ finds naps refreshing □ dreams during naps □ has episodes where his/her muscles do not work with a strong emotion (e.g. happiness, laughter, anger) □ has episodes of being unable to move muscles if awakening from sleep □ has episodes of seeing / hearing things (that do not seem to have occurred) when falling asleep or awakening from sleep

EQUIPMENT

1. Child uses:
   □ Supplemental O2
   If yes ⟶ □ 0.25 Lpm □ 0.5 Lpm □ 1 Lpm □ 1.5 Lpm □ 2 Lpm □ Other _____
   □ CPAP at_____ □ BPAP □ IPAP@_____ □ EPAP@ _____
   □ Ramp:_____□ Heated humidification □ Pressure Release on expiration □ Mask
   □ DME Company: _____

_____ _____ _____ _____

Parent/Guardian signature | Reviewed by | Date | Time

For in-clinic use only

Temp	HR	RR	B/P	Wt. (kg)	Ht. (cm)	HC	O2 Sat

Pain Score	Pain Scale

Signature:_____Date:_____Time: _____