Pediatric Sleep Intake Paperwork

Today's date: ____________________

Completed intake paperwork helps our providers get to know patients and their medical history. We rely on its accuracy and completeness to provide the best care possible. Please take your time and inquire at our front desk or call (907) 331-3640 if you have any questions or are unsure how to complete any section of this form. You can fax this paperwork ahead of time to (907) 331-3647.

Your child's name: ______________________________

Gender: ☐ Male ☐ Female

Date of birth: ______________________________

Social security number: ______________________________

Parent/guardian name: ______________________________

Relationship: ______________________________

Mailing address: ______________________________

City/State/Zip: ______________________________

Phone: ____________________ ☐ Home ☐ Mobile ☐ Work

Email: ______________________________

Child's height: ______________________________

Child's weight: ______________________________

Insurance information

Primary insurance coverage: ______________________________

Policy number: ______________________________

Group number: ______________________________

Policy holder name: ______________________________

Policy holder DOB: ______________________________

Policy holder SSN: ______________________________

Relationship to patient: ______________________________

Secondary insurance coverage: ______________________________

Policy number: ______________________________

Group number: ______________________________

Policy holder name: ______________________________

Policy holder DOB: ______________________________

Policy holder SSN: ______________________________

Relationship to patient: ______________________________

You can access our patient portal at peakneurology.com and gain full access to your medical history. You can also message your provider, request prescription refills, update your personal information, and recieve a care summary after your visit.

Patient intake

Who is your pediatrician? ______________________________

Why were you referred to our office? ______________________________

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

____

What have you tried to help your child's sleep problem(s)? ______________________________

____

Medical history

Please mark any of the following disorders that your child has been diagnosed with:

- ☐ Allergies
- ☐ Asthma
- ☐ Cerebral palsy
- ☐ Chronic bronchitis
- ☐ Frequent ear infections
- ☐ Frequent nasal congestion
- ☐ Genetic disease
- ☐ Head/brain injury
- ☐ Hearing problems
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Obesity
- ☐ Obstructive sleep apnea
- ☐ Poor/delayed growth
- ☐ Reflux disease
- ☐ Seizures/epilepsy
- ☐ Sinus problems
- ☐ Speech problems
- ☐ Trouble breathing through the nose
- ☐ Vision problems

Please list any other medical problems your child has that are not listed:

Psychological history

Please mark any of the following disorders that your child has been diagnosed with:

- ☐ Anxiety
- ☐ Autism
- ☐ Behavioral disorder
- ☐ Depression
- ☐ Developmental delay
- ☐ Drug use/abuse
- ☐ Hyperactivity/ADHD
- ☐ Learning disability
- ☐ Obsessive compulsive disorder
- ☐ Psychiatric admission

Please list any other psychiatric problems your child has that are not listed:

Surgical and major hospitalization history

Please list all past surgical operations and/or major hospitalizations by date, operation/illness, and where they occurred.

Date	Operation/Illness	Name of hospital and/or surgeon	City and state

Family medical history

Please list the living status, age, medical problems, and/or cause of death for applicable family members.

Family member	Living status	Age, now or at a death	Medical problems	Cause of death
Mother	☐ Living ☐ Deceased			
Father	☐ Living ☐ Deceased			
Sibling ☐ M ☐ F	☐ Living ☐ Deceased			
Sibling ☐ M ☐ F	☐ Living ☐ Deceased			
Sibling ☐ M ☐ F	☐ Living ☐ Deceased			

Medication list

Please list any medications your child is currenly taking, including medications taken on an as needed basis and supplements/other over the counter medications.

Medication name	Strength/Dose	How many, and how often?

Social history

Does your child use any of the following:

Substance	Currently use?	Previously used?	Type	Amount
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No		______ per day
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No		______ drinks per week
Caffiene	☐ Yes ☐ No	☐ Yes ☐ No		______ drinks per week
Illicit drugs	☐ Yes ☐ No	☐ Yes ☐ No		______ drinks per day

Is your child exposed to cigarette smoke? ☐ Yes ☐ No

School Performance

	Yes	No
Has your child ever repeated a grade?		
Is your child enrolled in special education classes?		
What grade is your child in?		
How many school days has your child missed this year?		
How were your child’s grades last year?		

Sleep History and Symptoms		
Does your child have regular sleep time? ☐ Yes ☐ No		
	On weekdays	On weekends
What time does your child go to bed?		
What time does your child get up in the morning?		
How many hours of sleep does your child get per night?		
How many hours does your child nap?		

Does your child (pleave leave blank if unknown):	Never	Sometimes (1-2 times per week)	Routinely (3-5 times per week)	Always (6-7 times per week)
Have trouble getting up in the morning?				
Fall asleep at school?				
Nap after school or at inappropriate times?				
Have daytime sleepiness?				
Have hyperactivity or behavioral problems?				

In the past month, have you observed your child:	Yes	No	Don't know/ not sure
Snoring more than half of observed nights?			
Always snoring?			
Snoring loudly?			
Having loud or heavy breathing?			
Having trouble breathing or struggling to breath?			
Stopping breathing during the night?			
Breathing through their mouth during the daytime?			
Having a dry mouth when waking up?			
Wetting the bed?			
Being hard to wake in the morning?			
Complaining of headaches in the morning?			
Appearing to have stopped growing at a normal rate since birth?			
Seeming to not listen when spoken to directly?			
Having difficulty with organizing tasks/activities?			
Appearing easily distracted by external/environmental stimuli?			
Fidgeting with hands/feet or squirming when seated?			
Seeming "on the go" or appearing as if "driven by a motor"?			
Interrupting or intruding on others (such as while talking)?			

Movement/parasomnia symptoms

Does your child:	Yes	No	Don't know/ not sure
Complain of an uncomfortable feeling in his/her legs(creepy crawly feeling) during the waking hours?			
Kick his/her legs during sleep?			
Have nightmares or night terrors?			
Clench or grind his/her teeth at night?			
Frequently wet the bed?			
Stop breathing during the night?			
Breathe through their mouth during the daytime?			
Complain of having a dry mouth when waking up?			
Walk in his/her sleep?			
Talk in his/her sleep?			
Report sudden muscle weakness and/or lose control of his/her muscles with strong emotions?			
Report an inability to move when falling asleep or waking up?			
Report vivid dreams just before falling asleep or waking up?			

Drowsiness rating scale (please indicate chance of your child falling asleep with the given options)
(0) No chance (1) Slight chance (2) Moderate chance (3) High chance

Situation	Rating
Sitting and reading	
Watching TV or a video	
Sitting in a classroom at school or during the morning	
As a passenger in a car or bus for half and hour	
Lying down to rest or nap in the afternoon	
Sitting and talking to someone	
Sitting quietly alone after lunch	
Sitting and eating a meal	

EDSS total: ____________

Please return forms to front desk once completed.