The Sleeptime OT

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Intake Questionnaire

General Client Information

Name: _____

Email: _____

Phone Number: _____

Address: _____

Child's Name: _____

Child's Date of Birth: _____

What are your sleep goals for your child?: _____

_____

Are you the primary caregiver for your child? Please list any other caregivers and describe their involvement in care for your child: _____

_____

Schedule

What time does your child wake up?: _____

What time do you put your child to bed?: _____

Does your child nap during the day? How often, for how long and at what times?:_____

_____

Does your child attend daycare at all? If yes, what is his/her daycare schedule and does he/she nap at all during daycare?: _____

_____

Describe your child's bedtime routine, if any: _____

_____

_____

_____

How long does it take your child to fall asleep?: _____

_____

How often does your child wake up during the night and for how long? How do you respond?: _____

_____

_____

_____

_____

Do you use any aids to help your child sleep? Soother, sound machine, mobile, swaddling, singing, bouncing, rocking, etc.: _____

_____

_____

_____

_____

Sleep Environment

Does your child bedshare (sleep in your bed), co-sleep (sleep in a separate crib in your room, or sleep in his/her own room?: _____

Briefly describe your child's nighttime sleep environment. Crib, room temperature, lighting, sleep clothes, noise, etc.: _____

_____

_____

Briefly describe your child's nap environment. Crib, room temperature, lighting, sleep clothes, noises, etc.: _____

_____

_____

Experience with Sleep Training

Have you tried sleep training in the past? If yes, please describe the method(s) you used and explain what was and wasn't successful: _____

_____

_____

_____

_____

_____

Are there any sleep training methods you do or do not want to use?: _____

_____

_____

Personal and Medical History

How would you describe your child's mood during the day on average?: _____

_____

Who is your child's pediatrician?: _____

Does your child or has your child previously had any diagnosed medical conditions or concerns? If yes, please describe: _____

_____

_____

_____

Is your child being actively monitored for any medical conditions or concerns? If yes, please describe: _____

_____

_____

_____

_____