CHILD/ADOLESCENT SLEEP EVALUATION

Patient Name: _____ Date of Birth:_____

Does your child suffer from the following?	**YES**	**NO**
Snores?		
Heavy or loud breathing?		
Pauses in breathing?		
Grinding of teeth?		
Coughing or choking in sleep?		
Restless sleep / tosses and turns a lot throughout the night?		
Unusual sleeping positions?		
Night terrors?		
Nighttime sweating?		
Sleep walks?		
Bed wetting?		
Hard to get out of bed in the morning seeming groggy and still very sleepy?		
Morning headaches?		
Daytime sleepiness?		
Falls asleep during school, short car rides, or on school bus?		
Inattention/struggles with focusing?		
Learning problems or struggles in school?		
Behavioral problems? (hyperactivity, impulsivity, rebelliousness, aggression)		
Mouth breathing?		
Nasally voice?		
Dark circles under eyes?		
Often sick?		
Allergies?		
Has or had frequent ear infections?		
Tubes in ears?		

Doctor's Evaluation:

High palate / narrow arch Crowding Crossbite

Wear Tonsil grade R: L: Mallampati

Tongue Tie Tongue posture Swallowing habit

Airway constriction on ceph Face Profile

Does this child need ENT T&A referral? YES NO

Does this child need orthodontic expansion? YES NO

Does this child need myofunctional therapy? YES NO