Colorado Couples Therapy, PLLC

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Sleep Assessment

Parent's Name(s):

Address (including zip code):

Child's Name: Age of child: Date of birth:
Sibling's Name: Age of child: Date of birth:
Sibling's Name: Age of child: Date of birth:
Home Phone Number:
Cell Phone Number:
Work Phone Number:
Email Address:
Preferred method of contact:
Name and address of Pediatrician:

How did you hear about us?

1. Are you a single parent? Yes No

2. Do you have a nanny that comes to your home? Yes No (skip to question 3)
   If so, how many hours/week?
   What days/times is your nanny with your child?
   Monday:
   Tuesday:
   Wednesday:
   Thursday:
   Friday:

Saturday:
Sunday:

3. Is your child in daycare/school? Yes No (skip to question 4)
   If so, how many hours/week?
   What days/times is your child in daycare/school?
   Monday:
   Tuesday:
   Wednesday:
   Thursday:
   Friday:
   Saturday:
   Sunday:
4. Where does your child sleep in the course of a day (check all that apply):
   Crib/Bassinet Car Seat Stroller Parent's Bed
   Swing Big Kid's Bed Bouncy Seat Other

5. Where does your child sleep at night?
   Own Room Room Shared With A Sibling Parent's Bedroom
   Do you have a family bed? Yes No
   Do you want to maintain a family bed? Yes No

6. Have you experienced any life changing events in the past six months? (please check any that apply)
   New Baby Moved Death in Family Divorce
   Return to Work Loss of Job Other

7. Have you recently taken a vacation? Yes No
   If so, where and how long?
   Do you have plans for a vacation in the near future? Yes No
   If so, when?

8. Has your child had any illnesses? Yes No
   If so, what and how long?

Does your pediatrician state that your child is physically able to sleep through the night? Yes No

9. Does your child have any ongoing health issues? Yes No
Chronic ear infections Asthma Allergies Other

10. Please check all that applies to your child:

____ snores
____ noisy breather
____ breathes through mouth
____ chokes or coughs during the night
____ sweats a lot during the night
____ appears extremely confused when s/he wakes during the night
____ rocks to sleep or bangs head when falling to sleep
____ kicks legs in a rhythmic fashion when sleeping
____ very restless sleeper

11. Please check the following adjectives that frequently could describe your child on any given day or evening:

____ cranky
____ irritable
____ wired
____ hyperactive
____ cries daily or frequently[
____ body tension, i.e. arching back, kicking legs and arms
____ unable to fall asleep easily
____ "crashes" from exhaustion
____ defiant
____ difficult temperament
____ "off the wall" behavior
____ irritable
____ wakes up at night
____ slow to wake in the morning
____ tired during the day

12. What time does your child go to bed?
What time does your child wake up?
Do these times vary from day to day? Yes No
If yes, check which time varies:
_____Bedtime ____Wake time ___Bedtime & Wake time

13. Please describe your child's bedtime routine from beginning to end (what happens about a half hour before bed)

Does the order vary from night to night? Yes No

14. Is your child sensitive to changes in routines that affect their sleep patterns (i.e., sleeping in a different room/bed while on vacation, etc.)?
Yes No

15. Is your child a "light" sleeper? Yes No

16. How many times does your child wake during the night?

17. What do you do in response to your child waking at night?

20. How hard is it for you to hear your child cry with 10 being the most difficult?
Not Difficult **Very Difficult**
1 2 3 4 5 6 7 8 9 10

20. Do you and your partner disagree on your child's sleep habits? Yes No

21. Do you and your partner disagree on how to discipline your child? Yes No

22. Did you try any strategies in the past to address this issue? Yes No

If yes, what did you try and what was the result?

Please answer the questions pertinent to your child's age:

AGES 0-36 MONTHS

1. Did your child have colic as a baby? Yes No
   If so, please describe the colic?
   At what age did it stop?

2. Are you nursing? Yes No
   If yes, how often would you like to nurse at night?
   Would you like to wean? Yes No
   If so, when?

3. Is your child eating solids? Yes No
   If yes, how old was your child when you began feeding solids?
   How many solid meals does your child receive per day?

4. Do your child use a pacifier? Yes No
   If yes, when and how often does your child have a pacifier?
   Do you wish to continue using a pacifier? Yes No
   Do you want your child to use a pacifier at night? Yes No

5. Does your child nap? Yes No
   If so, what is his/her nap schedule?
   If no, did your child ever nap in the past and what was the schedule?

6. How many hours does your child watch television weekly?
   How many hours of computer time does your child average weekly?

AGES 3-12 YEARS

1. Does your child complain of headaches or stomachaches, especially towards the end of the day (and otherwise appears healthy)? Yes No

2. Does your child nap? Yes No
   If so, how often and for how long?

3. Does your child frequently complain of being bored? Yes No

4. How many hours does your child watch television weekly?
   How many hours of computer time does your child average weekly?

5. Does your child exhibit *any* behavioral problems in school or with peers (i.e., engage in conflict, hitting, pushing, spitting, yelling)? Yes No
   If yes, please explain.

6. Does your child have any academic or learning issues and/or concerns? Yes No
   If yes, please explain.

Please write any additional comments you feel are pertinent: