Client Intake Form

PARENTS NAMES:

EMAIL(S):

PHONE NUMBER(S):

HOME ADDRESS(FOR IN-HOME VISITS):

Family/Child History

Child's Name:

Age/Birthdate:

Was your child born on time, early, or late?

What is your child's temperament throughout the day?

Is your child in daycare or school? If so, what times?

Are there any other children in your household? If so, what are their ages?

Current Sleep Schedule

What time does he/she wake up for the day?

Does he/she nap? What are the times and durations of these naps?

What time does he/she go to bed?

Do you have a bedtime routine?

What is your child's feeding schedule like?

Does he/she still get a feeding in the middle of the night?

If so, what times do these typically occur?

Bottles or nursings?

How long does it take to go back to sleep afterwards?

Does your child wake up at other times throughout the night?

If, so are they specific times?

What do you do to put he/she back to sleep and how long does it take?

Sleep Environment

Where does your child sleep? (Own room, with parents, with siblings, in a crib, family bed, etc.)

Rate the darkness of your child's sleep environment:

1 2 3 4 5 (1=bright 5= completely dark)

Rate the noise level of your child's sleep environment:

1 2 3 4 5 (1=silent 5= loud and noisy)

When I put my child to sleep he/she is:

1 2 3 4 5 (1 = wide awake 5=very deep sleep)

Is there anything that helps your child fall asleep? (pacifier, rocking, lovey, etc.)

Does your child mouth breathe or snore?

Does your child have any medical issues I should be aware of?

What is the general history of your child's sleep habits since birth?

Is there anything else you would like for me to know about your child or your family?

MonkeyRoo Sleep Consulting