Child Sleep & Breathing Questionnaire

Patient Information

Patient First Name _____ Patient Last Name _____ Preferred Name _____ Date of birth _____ Sex: _____

Cell Phone _____ Email _____

Please indicate if your child experiences or has experienced any of the symptoms below by using this scale to measure the severity of these symptoms.

Snoring During Sleep _____ Wetting/History of wetting the bed _____ Headaches/TMJ Pain _____ Grinding During Sleep _____ Wakes up at night _____ Mouth breathing Either During the Day/Night _____

Trouble focusing during the day _____ Daytime Drowsiness/ Fatigue/ Irritability _____ Seasonal Allergies _____ Frequent sinus/ throat/ ear infections _____ Anxiety/depression _____ ADD/ADHD _____

Parent/Guardian Signature

Sign