Queen City Pediatric Sleep Solutions
Client Assessment Form

Child's Name: Age and Full Birthdate:

How many weeks at birth was your child born?

Parent's Name
Address(home consult)

Email:
Phone Number(s):

Please take a few minutes and tell me more about your child/family.

1. Are there any siblings in the home? Ages? Is there any other family living in the home?

2. Does your child have any medical issues to be aware of or take any medications that might affect sleep? Does your child currently take melatonin?

3. Does your child snore or mouth breathe?

4. Have you discussed sleep training with your pediatrician? What was their response?

5. What time does your child wake for the day?

6. Is your child still napping? If yes, how many times per day and what are the times/durations?

7. What is the child's normal bedtime? Do you have a specific bedtime routine you follow? Please describe.

8. Does your child wake for feedings? If yes, how many times? What time do these wakings typically happen?

9. Does your child experience night wakings(other than for feeding)? How are they typically handled? Include who tends to the wakings and what each person does to soothe the child.

10. Does your child attend daycare? What are the hours?

11. If the child is at home, are the caregivers on board with sleep training?

12. Please describe your child's sleep environment(does the child sleep in a crib, room share, bed share, is the room dark, noise level in home, room temperature).

13. What is your child's process for falling asleep(does the child fall asleep while feeding, rocking, being held, do you have to lay down with them)? When you put your child down for sleep, please describe their state of wakefulness.

14. Please describe your child's temperament during the day(especially in the late afternoon).

15. Has your family experienced any loss/trauma or major changes recently? How has this affected your child?

16. Is everyone in the household committed to your child getting restful and restorative sleep?

17. Are there any sleep training philosophies that you are uncomfortable with? Please explain.

18. Are there any sleep training methods you have tried? Please explain.

19. Please describe in as much detail as possible your goals for this process for your child, yourself and your family?

20. Is there anything else you feel I should know about your child and/or family?

21. How did you hear about Queen City Pediatric Sleep Solutions?

Thank you for taking the time to provide me with this information. I look forward to working with your family to help you all get a better and more restful night's sleep.