National Jewish Health™
Science Transforming Life®

1400 Jackson Street
Denver, Colorado 80206
303.388.4461
www.nationaljewish.org

Dear Parent or Guardian of

Welcome to the National Jewish Health Pediatric Sleep Clinic. This letter is to confirm your appointment with Dr. Meltzer on _____/_____/_____ at _____p.m. Please report to the Pediatric Check-in desk on the second floor of the May Building.

If you are running late or cannot keep your scheduled appointment, please call 303-398-1355 as it may be necessary to reschedule your appointment.

In order to expedite your appointment **please review and complete the attached questionnaire, including a sleep diary that should be completed for 1-2 weeks prior to your child's visit,** and bring it with you at the time of the visit. **This form is an important part of your initial visit**.

PLEASE NOTE:

1. National Jewish Health treats many people with respiratory disorders whose symptoms can be triggered by certain scents. **Please DO NOT wear any of the following**:
   - Perfumes
   - Scented lotions
   - Colognes
   - Aftershave

2. **Parent or Legal Guardian MUST accompany all patients under the age of 18.** If this is hardship (Mom and/or Dad cannot get off from work) for follow up appointments, please discuss this with the physician at the time of your first appointment and we will try and make a plan with you.

If you have any questions prior to your visit, please call 303-398-1260.

PLEASE CHECK IN FOR YOUR APPOINTMENT WITH DR. MELTZER ON THE SECOND FLOOR OF THE MAY BUILDING IN THE PEDIATRIC CLINIC

SLEEP LOG INSTRUCTIONS

- Please keep a daily log of your child's sleep for every day (for up to two weeks) before their clinic visit.

- To show the time your child gets in bed, please mark that time with a down arrow (↓).

- Please shade in the time that your child is asleep.

- To show the time your child wakes up and/or gets out of bed (either during the night or in the morning), please mark that time with an up arrow (↑).

On the bottom of your sleep log is an example line. The markings show that this child went to bed at 9:30pm (↓), was asleep from 10:00pm to 2:00am (↑), was awake and/or out of bed from 2:00-3:00am, and was asleep again from 3:00am to 7:00am, and got out of bed at 7:30am. This child also took a nap from 1:00pm to 3:00pm.

Please note, each day of the sleep diary starts at 6pm, so if you are recording for Tuesday, you will start with Tuesday at 6pm and record through Wednesday 6pm on the first line. The second line will be Wednesday 6pm through Thursday 6pm, and so on.

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Sleep Diary

Name: Dob: / /

Date Started: / / Date Ended: / /

List Medications:

Day	6p	7	8	9	10	11	12	Midnight 1	2	3	4	5	6	7	8	9	10	11	12	Noon 1	2	3	4	5	Comments

Day	6p	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	Comments
Example				↓	■	■	■	■	↑	↓	■	■	■	■	↑					↓	■	■	↑			

Key: down arrow = in bed up arrow = out of bed shaded = asleep (can have unshaded space between arrows, in bed not asleep)

NJ4Kids Sleep Clinic, National Jewish Health, Denver, CO Fax: (303)270-2141 attn: Lisa Meltzer

Sleep Evaluation Questionnaire

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

CHILD'S INFORMATION			
Child's name:		Child's gender: ☐ Male ☐ Female	
Child's birth date:		Child's age:	
Child's racial/ethnic background:	☐ White/Caucasian	☐ Black/African-American	☐ Asian-American
	☐ Native-American	☐ Hispanic-Latino	☐ Multi-racial
	☐ Other		

What are your major concerns about your child's sleep?
What things have you tried to help your child's problem?

SLEEP HISTORY

Weekday Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period on weekdays (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on weekday nights : _____:_____

The child's usual waketime on weekday mornings: _____:_____

Weekend/Vacation Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period during weekends and vacations (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on weekend/vacation nights : _____:_____

The child's usual waketime on weekend/vacation mornings: _____:_____

Nap Schedule

Number of days each week child takes a nap: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

If child naps, write in usual nap time(S): Nap 1: ____ : ____ ☐ a.m. ☐ p.m. to ____ : ____ ☐ a.m. ☐ p.m.

Nap 2: ____ : ____ ☐ a.m. ☐ p.m. to ____ : ____ ☐ a.m. ☐ p.m.

General Sleep

Does the child have a regular bedtime routine? ☐ yes ☐ no

Does the child have his/her own bedroom? ☐ yes ☐ no

Does the child have his/her own bed? ☐ yes ☐ no

Is a parent present when your child falls asleep? ☐ yes ☐ no

Child usually falls asleep in...	Child sleeps most of the night in...	Child usually wakes in the morning in...
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ own room in own bed (alone)
☐ parents' room in own bed	☐ parents' room in own bed	☐ parents' room in own bed
☐ parents' room in parents' bed	☐ parents' room in parents' bed	☐ parents' room in parents' bed
☐ sibling's room in own bed	☐ sibling's room in own bed	☐ sibling's room in own bed
☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed

Child is usually put to bed by: ☐ Mother ☐ Father ☐ Both Parents ☐ Self ☐ Others

Write in the amount of time the child spends in his/her bedroom before going to sleep: _____ minutes

Child resists going to bed?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child has difficulty falling asleep?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child awakens during the night?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no

After nighttime awakening, child has difficulty falling back to sleep?	☐ yes ☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no
Child is difficult to awaken in the morning?	☐ yes ☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no
Child is a poor sleeper?	☐ yes ☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no

Current Sleep Symptoms

		(a) never (does not happen)	(b) not often (less than 1 night/day a week)	(c) sometimes (1 to 2 nights/days a week)	(d) often (3 to 5 nights/days a week)	(e) always (6 to 7 nights/days a week)	(f) do not know
1.	Difficulty breathing when asleep	a	b	c	d	e	f
2.	Stops breathing during sleep	a	b	c	d	e	f
3.	Snores	a	b	c	d	e	f
4.	Restless sleep	a	b	c	d	e	f
5.	Sweating when sleeping	a	b	c	d	e	f
6.	Daytime sleepiness	a	b	c	d	e	f
7.	Poor appetite	a	b	c	d	e	f
8.	Nightmares	a	b	c	d	e	f
9.	Sleepwalking	a	b	c	d	e	f
10.	Sleeptalking	a	b	c	d	e	f
11.	Screaming in his/her sleep	a	b	c	d	e	f
12.	Kicks legs in sleep	a	b	c	d	e	f
13.	Wakes up at night	a	b	c	d	e	f
14.	Gets out of bed at night	a	b	c	d	e	f
15.	Trouble staying in his/her bed	a	b	c	d	e	f
16.	Resists going to bed at bedtime	a	b	c	d	e	f
17.	Grinds his/her teeth	a	b	c	d	e	f
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19.	Wets bed	a	b	c	d	e	f

Current Daytime Symptoms							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 day a week)				
		(a) never (does not happen)					
1.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f

PREGNANCY / DELIVERY			
Pregnancy	☐ Normal	☐ Difficult	
Delivery	☐ Term	☐ Pre-term	☐ Post-term
Child's birthweight:			
Only child?	☐ Yes	☐ No	If no, circle birth order: 1st 2nd 3rd 4th 5th 6th 7th

MEDICAL AND PSYCHIATRIC HISTORY			
PAST MEDICAL HISTORY			
Frequent nasal congestion	☐ Yes	Age of diagnosis:	
Trouble breathing through his/her nose	☐ Yes	Age of diagnosis:	
Sinus problems	☐ Yes	Age of diagnosis:	
Chronic bronchitis or cough	☐ Yes	Age of diagnosis:	
Allergies	☐ Yes	Age of diagnosis:	Allergic to what:
Asthma	☐ Yes	Age of diagnosis:	
Frequent colds or flus	☐ Yes	Age of diagnosis:	
Frequent ear infections	☐ Yes	Age of diagnosis:	
Frequent strep throat infections	☐ Yes	Age of diagnosis:	
Difficulty swallowing	☐ Yes	Age of diagnosis:	
Acid reflux (gastroesophageal reflux)	☐ Yes	Age of diagnosis:	
Poor or delayed growth	☐ Yes	Age of diagnosis:	
Excessive weight	☐ Yes	Age of diagnosis:	
Hearing problems	☐ Yes	Age of diagnosis:	
Speech problems	☐ Yes	Age of diagnosis:	
Vision problems	☐ Yes	Age of diagnosis:	
Seizures/Epilepsy	☐ Yes	Age of diagnosis:	
Morning headaches	☐ Yes	Age of diagnosis:	
Cerebral palsy	☐ Yes	Age of diagnosis:	
Heart disease	☐ Yes	Age of diagnosis:	
High blood pressure	☐ Yes	Age of diagnosis:	
Sickle cell disease	☐ Yes	Age of diagnosis:	
Genetic disease	☐ Yes	Age of diagnosis:	
Chromosome problem (e.g., Down's)	☐ Yes	Age of diagnosis:	
Skeleton problem (e.g., dwarfism)	☐ Yes	Age of diagnosis:	
Cranofacial disorder (e.g., Pierre-Robin)	☐ Yes	Age of diagnosis:	
Thyroid problems	☐ Yes	Age of diagnosis:	
Eczema (itchy skin)	☐ Yes	Age of diagnosis:	
Pain	☐ Yes	Age of diagnosis:	

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY		
Autism	☐ Yes	Age of diagnosis:
Developmental delay	☐ Yes	Age of diagnosis:
Hyperactivity/ADHD	☐ Yes	Age of diagnosis:
Anxiety/Panic Attacks	☐ Yes	Age of diagnosis:
Obsessive Compulsive Disorder	☐ Yes	Age of diagnosis:
Depression	☐ Yes	Age of diagnosis:
Suicide	☐ Yes	Age of diagnosis:
Learning disability	☐ Yes	Age of diagnosis:
Drug use/abuse	☐ Yes	Age of diagnosis:
Behavioral disorder	☐ Yes	Age of diagnosis:
Psychiatric Admission	☐ Yes	Age of diagnosis:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.

CURRENT MEDICAL HISTORY

Please list any medications your child currently takes:

Medicine	Dose	How often?
1.		
2.		
3.		
4.		

LONG-TERM MEDICAL PROBLEMS

If your child has long-term medical problems, please list them.

SURGERIES/HOSPITALIZATIONS			
Has your child ever had his/her tonsils removed?	☐ Yes	Age of surgery:	Reason for surgery:
Has your child ever had his/her adenoids removed?	☐ Yes	Age of surgery:	Reason for surgery:
Has your child ever had ear tubes?	☐ Yes	Age of surgery:	
Please list any additional hospitalizations or surgeries:			

HEALTH HABITS			
Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)	☐ No	☐ Yes	Amount per day:

SCHOOL PERFORMANCE					
CURRENT SCHOOL PERFORMANCE (if school-aged)					
Your child's grade:					
Has your child ever repeated a grade?	☐ No	☐ Yes			
Is your child enrolled in any special education class?	☐ No	☐ Yes			
How many school days has your child missed so far this year?					
How many school days did your child miss last year?					
How many school days was your child late so far this year?					
How many school days was your child late last year?					
Child's grades this year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing
Child's grades last year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing

FAMILY'S INFORMATION		
MOTHER		**FATHER**
Age:		Age:
Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried		Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried
Education:		Education:
Work: ☐ Home full-time ☐ Part-time ☐ Full-time		Work: ☐ Home full-time ☐ Part-time ☐ Full-time
Occupation:		Occupation:

PERSONS LIVING IN HOME		
Name:	Relationship	Age

FAMILY SLEEP HISTORY				
Does anyone in the family have a sleep disorder? ☐ Yes ☐ No				
If yes, mark the disorder(s):				
Insomnia	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent

REFERRAL	

Who asked that your child be seen by a sleep specialist?

_____ Pediatrician/Family physician

_____ Child's parent or guardian

_____ Surgical specialist (e.g., ENT)

_____ Pediatric specialist (e.g., allergist, neurologist, pulmonolgist)

_____ Mental health specialist (e.g. psychiatrist, psychologist, social worker)

_____ School teacher, nurse, counselor

_____ Child himself/herself

_____ Other:

IF YOU WOULD LIKE A COPY OF YOUR CHILD'S EVALUATION TO BE SENT TO YOUR PRIMARY CARE PROVIDER (OR ANOTHER SPECIALTY PROVIDER):

- PLEASE PROVIDE THAT PERSON'S CONTACT INFORMATION ON THE FOLLOWING PAGE UNDER "**OUTSIDE AGENCY**"
- PLEASE SELECT ONE OF THE OPTIONS UNDER "**I GIVE MY PERMISSION**"
- PLEASE SIGN AND DATE THE FORM AT THE BOTTOM

IF YOU HAVE QUESTIONS ABOUT THIS FORM, PLEASE ASK DR. MELTZER AT THE TIME OF YOUR EVALUATION.

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AUTHORIZATION TO RELEASE PSYCHOSOCIAL HEALTH INFORMATION

REGARDING PATIENT:

Full Name _____ **Medical Record #** _____
Address _____
City _____ **State** _____ **Zip** _____
Phone # _____ **Date of Birth** _____

NATIONAL JEWISH HEALTH CLINICIAN **LISA J. MELTZER, PH.D.**
National Jewish Health: 1400 Jackson St.; Denver, CO 80206

OUTSIDE AGENCY
(Name)_____

_____
(Address)
_____
(City) (State) (Zip)

I GIVE MY PERMISSION (CHECK ONE)

- ☐ For the Outside Agency to provide information to National Jewish Health regarding my child
- ☐ For National Jewish Health to provide information to the Outside Agency regarding my child's evaluation and/or treatment at NJH
- ☐ For National Jewish Health and the Outside Agency to exchange information regarding my child

_____ By initialing this space, in addtion to behavioral health information I authorize the release of my child's health records that may include information indicating the presence of communicable diseases or veneral diseases such as, but not limited to syphilis, hepatitis, Human immunodeficiency virus (HIV) also known as acquired immune deficiency syndrome.

- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA privacy rule.
- I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation.
- This authorization will expire in 365 days from the date below unless I request one less than 365 days.

I, _____hereby authorize National Jewish Health, Department of Pediatric Behavioral Health, to release and/or obtain the information described above.

_____ Date:_____
Signature of patient, or parents, or legal Guardian if under 18 years of age

VERBAL CONSENT (To be used for Urgent or Emergent situations)

Verbal consent obtained this date _____ from the following in order not to delay records.

Name: _____Phone:_____

Address: _____
(City) (State) (Zip)

_____ _____
Verbal Witness Verbal Witness