Pediatric Comprehensive Health Questionnaire

Demographic Information

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

First Name: ____________ Middle Initial: ____ Last Name: ____________

Age: ________ Date of Birth: ____________ Height: ________ Weight: ________

Ethnicity: ☐Native American/Alaska Native ☐Asian ☐African American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other. ☐Decline to Answer

Responsible Party/Legal Guardian (if different than patient): ____________ Relationship: ________

Contact Information

Address: ____________ Address 2: ____________

City: ____________ State: ________ Zip: ________

Email: ____________ Home/Cell: ____________

Employer: ____________ Work Phone: ____________

Provider Information

Referral Source: ____________

Dental Provider Office: ____________ Last Visit: ____________

Dentist Name: ____________ Office Phone: ____________

City: ____________ Sate: ________ Zip: ________

Primary Care Physician Office: ____________ Last Visit: ____________

Doctor Name: ____________ Office Phone: ____________

City: ____________ Sate: ________ Zip: ________

Additional Provider Office: ____________ Last Visit: ____________

Doctor Name: ____________ Office Phone: ____________

City: ____________ Sate: ________ Zip: ________

Patient/Parent Signature: ____________ Date: ________

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What is your chief concern and reason for this visit:

___

Does your child currently experience any of the following symptoms?

Indicate all that apply and number your top chief complaints 1-4

Sleep Conditions

Regular bedtime	☐Yes ☐No	Resist going to bed	☐Yes ☐No
Difficulty falling asleep	☐Yes ☐No	Awakenings from sleep	☐Yes ☐No
Difficulty awakening in AM	☐Yes ☐No	Poor sleeper	☐Yes ☐No
Snoring	☐Yes ☐No	Mouth breathing	☐Yes ☐No
Restless sleep	☐Yes ☐No	Sweating when sleeping	☐Yes ☐No
Daytime sleepiness	☐Yes ☐No	Poor appetite	☐Yes ☐No
Nightmares	☐Yes ☐No	Sleepwalking	☐Yes ☐No
Sleep talking	☐Yes ☐No	Sleep terrors	☐Yes ☐No
Leg kicking	☐Yes ☐No	Getting out of bed	☐Yes ☐No
Teeth grinding	☐Yes ☐No	Growing pains	☐Yes ☐No
Bed wetting	☐Yes ☐No	Daytime sleepiness	☐Yes ☐No
Naps after school	☐Yes ☐No	Falls asleep at school	☐Yes ☐No

Other ___

Pain Conditions

Headaches	☐Yes ☐No	Jaw pain	☐Yes ☐No
Neck pain	☐Yes ☐No	Back pain	☐Yes ☐No
Noises in jaw joints	☐Yes ☐No	Difficulty opening mouth	☐Yes ☐No
Growing pains	☐Yes ☐No		

Other ___

Other Conditions

Nasal congestion	☐Yes ☐No	Difficulty breathing through nose	☐Yes ☐No
Bronchitis	☐Yes ☐No	Asthma	☐Yes ☐No
Allergies	☐Yes ☐No	Frequent colds or flu	☐Yes ☐No
Ear infections	☐Yes ☐No	Throat infections	☐Yes ☐No
Tonsillitis	☐Yes ☐No	Acid reflux (GERD)	☐Yes ☐No
Delayed growth	☐Yes ☐No	Fussy eater	☐Yes ☐No
Excessive weight	☐Yes ☐No	Tubes in ears	☐Yes ☐No
Hearing disorders	☐Yes ☐No	Speech problems	☐Yes ☐No
Vision problems	☐Yes ☐No	Seizures/epilepsy	☐Yes ☐No
Chromosomal disorders	☐Yes ☐No	Eczema	☐Yes ☐No
Tooth crowding	☐Yes ☐No	Delayed tooth eruption	☐Yes ☐No
Tongue-tie	☐Yes ☐No	Drooling while eating	☐Yes ☐No
Autism	☐Yes ☐No	Developmental delay	☐Yes ☐No
Hyperactivity ADHD	☐Yes ☐No	Anxiety/Panic Attacks	☐Yes ☐No
Obsessive Compulsive Disorder	☐Yes ☐No	Depression	☐Yes ☐No
Learning disability	☐Yes ☐No	Drug abuse	☐Yes ☐No
Behavioral disorder	☐Yes ☐No	Psychiatric care	☐Yes ☐No

Other ___

Surgical History

Tonsils removed	☐Yes ☐No	Adenoids removed	☐Yes ☐No
Tubes in ears	☐Yes ☐No	Tongue-tie release	☐Yes ☐No
Tooth extractions	☐Yes ☐No		

Other ___

What are the results you are seeking from treatment:

___

Patient/Parent Signature: ___ Date: ___

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Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

☐ Anesthetics	☐ Antibiotics	☐ Aspirin
☐ Barbiturates	☐ Codeine	☐ Iodine
☐ Latex	☐ Metals	☐ Plastics
☐ Penicillin	☐ Sedatives	☐ Sulfa

☐ Food Allergies/Sensitivities ______________________________

Other: ______________________________

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason for Taking

☐ See attached list

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (y/n)

☐ See attached list

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? __________

Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? ☐Yes ☐No

If yes, what conditions: ______________________________ Date of accident: __________

Does any family member have a sleep breathing disorder? ☐Yes ☐No If yes, explain: ______________________________

Has your child had any of the following:

Orthodontic Treatment? ☐Yes ☐No

Stopped breathing during sleep? ☐Yes ☐No

Sleep Study? ☐Yes ☐No

☐HST (Home Sleep Test) ☐PSG (Polysomnogram in Sleep Lab) Date: __________ Result: __________

Positive Airway Pressure Devices Used? ☐CPAP ☐BiPAP ☐ASV ☐APAP

Orthodontic Appliance? ☐Yes ☐No Type: __________

Myofunctional Therapy? ☐Yes ☐No Type: __________

Other Therapy? ☐Yes ☐No Type: __________

Breastfed ☐Yes ☐No Until what age? __________

Bottle fed ☐Yes ☐No Until what age? __________

Pacifier ☐Yes ☐No Until what age? __________

Thumb or Finger Habit ☐Yes ☐No Until what age? __________

Other ______________________________

Medical History

AIDS/HIV	☐ Yes ☐No
Anemia	☐ Yes ☐No ☐Fam Hx
Anxiety	☐ Yes ☐No ☐Fam Hx

Patient/Parent Signature: ______________________________ **Date:** __________

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Condition	Response
Asthma	☐ Yes ☐No ☐Fam Hx
Bleeding Easily	☐ Yes ☐No ☐Fam Hx
Birth Defects	☐ Yes ☐No ☐Fam Hx
Bruising Easily	☐ Yes ☐No ☐Fam Hx
Cancer of ____________	☐ Yes ☐No ☐Fam Hx
Chemo	☐ Yes ☐No ☐Fam Hx
Chronic Fatigue	☐ Yes ☐No ☐Fam Hx
Cold Hands and Feet	☐ Yes ☐No ☐Fam Hx
COPD	**☐ Yes☐No☐Fam Hx**
Depression	**☐ Yes☐No☐Fam Hx**
Diabetes	**☐ Yes☐No☐Fam Hx**
Difficulty Concentrating	☐ Yes ☐No ☐Fam Hx
Difficulty Breathing at Night	☐ Yes ☐No ☐Fam Hx
Dizziness	☐ Yes ☐No ☐Fam Hx
Eating Disorder	☐ Yes ☐No ☐Fam Hx
(EDS) Ehlers-Danlos Syndrome	☐ Yes ☐No ☐Fam Hx
Emphysema	☐ Yes ☐No ☐Fam Hx
Epilepsy	☐ Yes ☐No ☐Fam Hx
Excessive Thirst	☐ Yes ☐No ☐Fam Hx
Fainting	☐ Yes ☐No ☐Fam Hx
Fibromyalgia	☐ Yes ☐No ☐Fam Hx
Fluid Retention	☐ Yes ☐No ☐Fam Hx
Frequent Colds/Flu	☐ Yes ☐No ☐Fam Hx
Frequent Cough	☐ Yes ☐No ☐Fam Hx
Frequent Ear Infections	☐ Yes ☐No ☐Fam Hx
Frequent Sore Throat	☐ Yes ☐No ☐Fam Hx
Awakening from Sleep ____ x	☐ Yes ☐No ☐Fam Hx
Gastroesophogeal Reflux	☐ Yes ☐No ☐Fam Hx
Glaucoma	☐ Yes ☐No ☐Fam Hx
Hay Fever	☐ Yes ☐No ☐Fam Hx
Hearing Impairment	☐ Yes ☐No ☐Fam Hx
Heart Attack	☐ Yes ☐No ☐Fam Hx
Heart Disease	**☐ Yes☐No☐Fam Hx**
Heart Murmur	☐ Yes ☐No ☐Fam Hx
Heart Pacemaker	☐ Yes ☐No ☐Fam Hx
Heart Palpitations	☐ Yes ☐No ☐Fam Hx
Heart Valve Replacement	☐ Yes ☐No ☐Fam Hx
Hemophilia	☐ Yes ☐No ☐Fam Hx
Hepatitis	☐ Yes ☐No ☐Fam Hx
High Blood Pressure	**☐ Yes ☐No☐Fam Hx**
History of Substance Abuse	☐ Yes ☐No ☐Fam Hx
Huntington's Disease	☐ Yes ☐No ☐Fam Hx
Hypoglycemia	☐ Yes ☐No ☐Fam Hx
Insomnia	**☐ Yes ☐No ☐Fam Hx**
Intestinal Disorder	☐ Yes ☐No ☐Fam Hx
Irregular Heartbeat	☐ Yes ☐No ☐Fam Hx
Kidney Disease	☐ Yes ☐No ☐Fam Hx
Leukemia	☐ Yes ☐No ☐Fam Hx
Liver Disease	☐ Yes ☐No ☐Fam Hx
Low Blood Pressure	☐ Yes ☐No ☐Fam Hx
Meniere's Disease	☐ Yes ☐No ☐Fam Hx
Memory Loss	☐ Yes ☐No ☐Fam Hx
Migraines	☐ Yes ☐No ☐Fam Hx
Mitral Valve Prolapse	☐ Yes ☐No ☐Fam Hx
Multiple Sclerosis	☐ Yes ☐No ☐Fam Hx
Muscle Aches	☐ Yes ☐No ☐Fam Hx
Muscle Fatigue	☐ Yes ☐No ☐Fam Hx
Muscle Spasms	☐ Yes ☐No ☐Fam Hx
Muscular Dystrophy	☐ Yes ☐No ☐Fam Hx
Neuralgia	☐ Yes ☐No ☐Fam Hx
Nervous system Disorder	☐ Yes ☐No ☐Fam Hx
Osteoarthritis	☐ Yes ☐No ☐Fam Hx
Osteoporosis	☐ Yes ☐No ☐Fam Hx
Ovarian Cyst	☐ Yes ☐No ☐Fam Hx
Parkinson's Disease	☐ Yes ☐No ☐Fam Hx
Poor Circulation	☐ Yes ☐No ☐Fam Hx
(POTS) Postural Orthostatic Tachycardia Syndrome	☐ Yes ☐No ☐Fam Hx
Psychiatric Care	☐ Yes ☐No ☐Fam Hx
Radiation	☐ Yes ☐No ☐Fam Hx
Recent Weight Gain	☐ Yes ☐No ☐Fam Hx
Recent Weight Loss	☐ Yes ☐No ☐Fam Hx
Rheumatic Fever	☐ Yes ☐No ☐Fam Hx
Rheumatoid Arthritis	☐ Yes ☐No ☐Fam Hx
Scarlet Fever	☐ Yes ☐No ☐Fam Hx
Shortness of Breath	☐ Yes ☐No ☐Fam Hx
Skin Disorder	☐ Yes ☐No ☐Fam Hx
Sinus Problems	☐ Yes ☐No ☐Fam Hx
Slow Healing Sores	☐ Yes ☐No ☐Fam Hx
Speech Difficulties	☐ Yes ☐No ☐Fam Hx
Stroke	**☐ Yes ☐No ☐Fam Hx**
Swollen or Painful Joints	☐ Yes ☐No ☐Fam Hx
Thyroid Disease	**☐ Yes ☐No ☐Fam Hx**
Tired Muscles	☐ Yes ☐No ☐Fam Hx
Tuberculosis	☐ Yes ☐No ☐Fam Hx
Urinary Tract Disorder	☐ Yes ☐No ☐Fam Hx
OTHER ______________________________	

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient/Parent Signature: ____ **Date:** __________

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BEARS SLEEP SCREENING

The "BEARS" instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of age-appropriate "trigger questions" for use in the clinical interview.

B = bedtime problems
E = excessive daytime sleepiness
A = awakenings during the night
R = regularity and duration of sleep
S = snoring

A parent answers questions in **black**, the subject child answers questions written in **blue**:

Symptom	Age Toddler/Preschool (2-5 years)	Age School Age (6-12 years)	Age Adolescent (13-18 years)
1. Bedtime Problems	Does your child have any problems going to bed? Y N	Does your child have any problems at bedtime? (P) Y N Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C) Y N
2. Excessive Daytime Sleepiness	Does your child seem overtired or sleepy a lot during the day? Y N	Does your child have difficulty waking in the morning, seem sleepy during the day or take naps? (P) Y N Do you feel tired a lot? (C) Y N	Do you feel sleepy a lot during the day? Y N In School? Y N While Driving? (C) Y N
3. Awakenings during the night	Does your child wake up a lot at night? (P) Y N	Does your child seem to wake up a lot at night? Y N Any sleepwalking or nightmares? (P) Y N Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N	Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? Y N What are they? _____	What time does your child go to bed and get up on school days? ____ ____________________ Weekends? _____________ Do you think he/she is getting enough sleep? (P) Y N	What time do you usually go to bed on school nights? ____ __________________ Weekends? ___________ How much sleep do you usually get? (C) _____________
5. Snoring	Does your child snore a lot or have difficult breathing at night? Y N	Does your child have loud or nightly snoring or any breathing difficulties at night? (P) Y N	Does your teenager snore loudly or nightly? (P) Y N

(P) Parent-directed question
(C) Child-directed question

Source: "A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems" by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins

Patient/Parent Signature: ____ **Date:** ___________

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PEDIATRIC SLEEP QUESTIONNAIRE (PSQ)

1. While sleeping does your child....

Snore more than half the time?	☐ Yes	☐No
Always snore?	☐ Yes	☐No
Snore loudly?	☐ Yes	☐No
Have "heavy" or loud breathing	☐ Yes	☐No
Have trouble breathing or struggle to breathe	☐ Yes	☐No
Have you ever seen your child stop breathing during the night?	☐ Yes	☐No

2. Does your child.....

Tend to breathe through the mouth during the day?	☐ Yes	☐No
Have a dry mouth on waking up in the morning?	☐ Yes	☐No
Occasionally wet the bed?	☐ Yes	☐No
Wake up feeling unrefreshed in the morning?	☐ Yes	☐No
Have a problem with sleepiness during the day?	☐ Yes	☐No
Have a teacher or other supervisor comment that your child appears sleepy during the day?	☐ Yes	☐No
Find it hard to wake your child up in the morning?	☐ Yes	☐No

3. Did your child stop growing at a normal rate at any time since birth? ☐ Yes ☐No

4. Is your child overweight? ☐ Yes ☐No

5. This child often.....

Does not seem to listen when spoken to directly.	☐ Yes	☐No
Has difficulty organizing tasks and activities.	☐ Yes	☐No
Is easily distracted by extraneous stimuli.	☐ Yes	☐No
Fidgets with hands or feet or squirms in seat.	☐ Yes	☐No
Is "on the go" or often acts as if "driven by a motor".	☐ Yes	☐No
Interrupts or intrudes on others (butts into conversations or games)	☐ Yes	☐No

Patient/Parent Signature: ______________________________ **Date:** __________

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AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW LISTED REFERRING AND TREATING HEALTH CARE PROFESSIONALS:

Doctors Name	Location/Phone

I authorize the release of communications regarding my treatment with ____________________________ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed ______________________________________ Date ____________

Patients printed Name: ______________________________

Private Patient Agreement

I am aware TMJ & Sleep Therapy Centre is not contracted with my insurance company. I am requesting to be seen as a private patient and completely understand I will be responsible for full fees on a private pay basis. I agree to pay for treatment services at the TMJ & Sleep Therapy Centre at the fees schedule based on the centre's private practice charges.

____

Signature Date

HIPAA – Privacy practices:

Acknowledgement of receipt of Notice of Privacy Practices:
I have received a copy of this office's Notice of Privacy Practices

____

Signature Date

Consent to Obtain External Prescription History

I, ____, whose signature appears below, authorize TMJ & Sleep Therapy Centre of Montana, Inc. and it's provider to view my external prescription history via Meditouch Practice Management. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by provider and staff at TMJ & Sleep Therapy Centre of Montana, Inc. This also may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

____

Signature Date