Client Welcome Packet

IMPACT MYOFUNCTONAL THERAPY

Formerly Integrative Myofunctional Therapy
Now Proud To Be Part of the Impact Health Solutions™ Brand

Welcome!

I'M HAPPY TO MEET YOU!

Hi, I'm Carmen, your myofunctional therapist extraordinaire!

I'm obsessed with all things tongue-ties, wellness, airways and sleep disordered breathing. I'm here to help you navigate through the messy and magical myofunctional journey.

My story is personal and close to home.

My sweet granddaughter was passed back and forth amongst doctors and therapists for years trying to figure out her speech, breathing, sleep, chewing and swallowing issues. It wasn't until I completed my postgraduate myofunctional training that I knew her problem was a significant tongue-tie. Bingo.

Fast forward to now. I'm a crusader. A warrior. A voice for those who can't find theirs, or who don't have one.

I see clients all over the world to provide expert guidance and specialized therapy.

I've created this guide to explain the process, and help you understand what it means to work with Impact Myofunctional Therapy.

I want you to know that all myofunctional therapists are not created equal...and I'm about to show you why.

Shall we?

Carmen

MY CONTACT INFO
carmen@myofunctionaltherapy4u.com

The IMT Difference

WHAT SETS US APART

Our core focus is you.

You're the hero here. Hugs and high fives to you for caring enough to be here. To know that you need to make a change. We are here to support you on that journey. We don't work with symptoms, we work with people.

Eating better. Chewing better. Swallowing better. Free from sleep concerns, digestive high's and lows, and speech trouble. We are only the cape. You're the superhero.

Working with Impact Myofunctional Therapy is not about price, it's about the UME.

Our Unique Myofunctional Experience (UME) is the reason people work with us. Quite honestly, price is just a small part of the whole equation and should never be used as the deciding factor if you're considering making changes for the long term!

Not only do we deliver innovative myofunctional therapy through a variety of programs that work, but our proven process, meticulous framework, success stories, and unparalleled client support put you in the driver's seat to experience a life-changing new normal.

What To Expect

WHEN WORKING WITH US

We want the best for you but we can't want it more than you do.

If you're a parent, seeking help for your child, we need your 150% commitment to do the work it takes for your child to be successful.

Because we only work with a select number of clients 1:1, it is important that we select the clients that are perfectly aligned for us!

When you choose to take us on your journey, we plan a meticulous framework for you.

Our expertise is focused around tongue-ties, wellness, airway and sleep disordered breathing. We plan every step around these 4 pillars.

Many of the exercises that we teach you are building blocks, and you must have the self-motivation to do the work so that we can progress forward.

We cannot move you or your child forward without having a solid foundation. We don't build houses on quicksand. Hard stop!

Can you pinky promise to commit to the journey?

Meet the Team

YOU HAVE CHOICES

We're excited to add Jessica to the team. Carmen hand-picked Jessica to join the team after mentoring and training Jessica to become an orofacial myofunctional therapist.

Jessica has taken a deep dive into all things related to children, airway and sleep. She will be seeing clients of all ages but specifically children with airway and sleep concerns.

When you choose to work with Jessica, you are still working with Carmen as well. Carmen completes your exam, creates your therapy template and gives detailed orders on what you need and what therapy to deliver.

You simply meet Jessica instead of Carmen. This creates more time for Carmen to work with the most complex clients as well as nutrition therapy clients.

Here's the cool thing. Carmen and all of her team meet every two weeks for a providers collaboration meeting where they discuss all current client cases and make sure every client is receiving premium level services that meet the high standards of the Impact Heath Solutions™ company.

It is almost like you instantly have a 2 person support staff!!

Client Homework

WHAT TO GET READY FIRST

DISCOVERY PAPERWORK COMPLETE

Complete this paperwork IN FULL and email: carmen@myofunctionaltherapy4u.com

Please submit this paperwork as soon as you have it done! Unfortunately, this will require printing and filling out. You only need to print the forms that need to be filled out and returned. Please write legibly. The discovery paperwork begins on page 11. Please see below for what ages need what paperwork.

Some questions may seem similar or redundant but please fill out completely and to the best of your ability. Attach additional information if you need to further explain.

A couple things to note:

- **Pittsburgh Sleep Quality Index** (**ages 18+**) is the gold standard for evaluating *sleep quality*.
- **Epworth Sleepiness Scale** (**ages 18+**) is the gold standard for evaluating *daytime sleepiness*.
- **Fatigue Severity Scale** (**ages 18+**) is used to evaluate the *impact of fatigue* on you.
- **Sleep Hygiene Index** (**ages 18+**) is used to help develop sleep health promotion strategies for you.
- **Quality of Life Scores** (**everyone**) is used to help us understand what you perceive as a problem.
- **Pediatric Sleep Questionnaire** (**under 18**) is used to identify sleep concerns in children.

When ready to return paperwork, please return as a PDF document. There are many simple, free apps that can turn your phone into a scanner, where you can save the image as a PDF. Our system needs to receive the files back as a PDF to be able to file it correctly.

Client Homework

NEXT...

ADD US ON SKYPE

- *Search CRABBIEJACK2 and add us as a contact.*

Be forewarned...there is a Crabbiejack / Carmen Woodland account that is old and we can't access it! You need to find CRABBIEJACK 2.

Or use this link: https://join.skype.com/invite/N3Qd7smdk28I

PLEASE do this ahead of time so it doesn't cause you stress during your valuable appointment time!

IN THE MEANTIME, LEARN MORE ABOUT US

- *Write down any questions you have!*

After receiving your paperwork, we will start working on your report. In the meantime, on the following pages, you will find information about our practice, the process, prices and anything else that we think is important for you to know about us!

Keep your questions handy, because you will want them answered during your assessment.

You can also visit our website for many free resources and helpful blog posts: www.myofunctionaltherapy4u.com

Service Price Sheet

HERE'S A LOOK AT OUR CURRENT SERVICE PRICING

ADULT PROGRAMS

Comprehensive 30 min 1:1

- 1 year long, unlimited sessions
- $3060+
- Payment plans available

Phase I Therapy 30 min 1:1

- 6 months long, 12 sessions
- $2520+
- Payment plans available

Phase I Therapy: 15 min 1:1

- 6 months long, 12 sessions
- $1800+
- Payment plans available

Our practice has worked with 1000's of clients and brings specialized expertise to your therapy.

Expertise is not developed by education or letters behind ones name. Instead it is nurtured and beautifully grown through experience and years of practice and refining.

During your comprehensive assessment, we help you choose the best program for your needs, personality and learning style.

YOUTH PROGRAMS

Youth Comprehensive

- 1 year long, unlimited sessions
- $3060+
- Payment plans available

Mini Myo

- 1 year long, 10 - 12 sessions
- $2025+
- Payment plans available

Other Services Available

We have several digital programs available and several others in production! If working with one of our therapists 1:1 does not seem like a good match at this time, perhaps a digital program would serve you will.

You can explore the current options on our website, https://www.myofunctionaltherapy4u.com/prices.

When you get to that webpage, just scroll down until you see the "digital programs" section.

In addition, Carmen is a Nutrition Therapy Practitioner, so these services are available for clients in her comprehensive wellness program.

Our Myo Process

HERE'S A LOOK AT OUR TIMELINE

STEP 1
Comprehensive Assessment

- Functional oral assessment
- Goals for therapy
- Breathing demonstration
- Choose a package

STEP 2
Choices & Kit

- Choose your therapist
- Get your therapy kit
- Take your photos
- Watch the video

STEP 3
Start Therapy: Phase I

- Frenectomy prep lasts 8 weeks
- Begin work on strength, coordination, neuromuscular connection, and proprioception
- TMD

STEP 4
Phase II and III Therapy

- Breathing
- Snoring / sleep apnea
- Sleep health promotion
- Behavior modification
- Eustacian tube dysfunction

TIMELINE INFORMATION

The timeline varies a little bit for everyone. Depending upon the program you choose, your therapy will last 6 months or 1 year. Also, we normally start therapy for a tongue-tie release 8 weeks prior to the procedure. However some circumstances lengthen or shorten this timeframe.

impact MYOFUNCTIONAL THERAPY

Discovery Checklist

Please check any/all that apply. It is incredibly important to **FULLY COMPLETE** this paperwork **LEGIBLY**, so allow me to best serve you.

Name:
Today's Date:
DOB:
Age:
Were you referred by someone? _____
Would you like us to communicate with your doctor? Yes / No
Dr. Name: _____
Dr. Email: _____
Where do you live? This helps us know if we have a provider / partner in your area. _____

Infancy/Early Childhood

- ☐ Difficulty nursing or used a nipple shield
- ☐ Fall asleep while nursing or need to nurse frequently
- ☐ Bottle-fed more than 50% of the time
- ☐ Had trouble with (or medicated for) reflux
- ☐ Colic symptoms or crying a lot, and unhappy
- ☐ Spit up often
- ☐ Gassy
- ☐ Messy feeding
- ☐ Chronic congestion
- ☐ Gagging/choking/coughing when eating
- ☐ Noisy / mouth breathing
- ☐ Multiple ear infections
- ☐ Tubes placed
- ☐ Difficulty transitioning to solid foods
- ☐ Other:

Airway / Breathing Concerns

- ☐ Asthma or any other breathing condition _____
- ☐ Allergies
- ☐ Dry, chapped lips
- ☐ Chronic congestion, unmedicated
- ☐ Chronic congestion, medicated
- ☐ Deviated septum
- ☐ Nasal surgery completed, details _____
- ☐ Nasal surgery recommended, details _____
- ☐ Tonsils removed
- ☐ Adenoids removed
- ☐ Tonsils enlarged
- ☐ Estimated % of **daytime** NASAL breathing? _____
- ☐ Estimated % of **nighttime** NASAL breathing? _____
- ☐ Trouble catching breath
- ☐ Over breathing/sighing
- ☐ Other:

Oral Resting Posture

- ☐ Full tongue rests on the roof of the mouth
- ☐ Full tongue rests in the middle of the mouth
- ☐ Full tongue rests on the floor of the mouth
- ☐ The tongue pushes on teeth
- ☐ Resting mouth posture is mouth closed with lips completely sealed
- ☐ Resting mouth posture is mouth closed with lips MOSTLY sealed
- ☐ Resting mouth posture is mouth open and lips open
- ☐ The lips are unable to close
- ☐ Other:

Digestive / Eating Behaviors / Chewing / Swallowing

- ☐ Frequent digestive issues
- ☐ Reflux: unmedicated
- ☐ Reflux: medicated
- ☐ Bloating
- ☐ Burping
- ☐ Hiccupping
- ☐ Gas
- ☐ Constipation
- ☐ Slow, adequate chewing on BOTH sides of the mouth
- ☐ Poor, quick chewing or chewing on one side of the mouth
- ☐ Slow eating behaviors because eating is a chore
- ☐ Rapid eating behaviors because I'm in a hurry to swallow
- ☐ Tongue thrusts forward during swallowing
- ☐ The back of the tongue doesn't lift during swallowing
- ☐ Difficulty with breathing while eating
- ☐ Open mouth chewing
- ☐ Use of liquids to swallow
- ☐ Difficulty swallowing pills
- ☐ Strong gag reflex
- ☐ Picky with textures
- ☐ Choking
- ☐ Prefer soft/easy to chew foods
- ☐ Eustachian tube concerns?
- ☐ Other:

Tongue-Tie History

- ☐ Lingual frenectomy as a baby
- ☐ Family members with tongue-ties
- ☐ Tongue-tie previously diagnosed by _____
- ☐ Labial / buccal tie suspected
- ☐ Previous frenectomy? When? _____
- ☐ Previous myofunctional therapy? When? _____

Sucking/ Toxic Oral Habits

- ☐ Thumb/finger sucking
- ☐ Prolonged pacifier use
- ☐ Another habit: _____

Dental / Orthodontic History

- ☐ For children under 18, age of first orthodontic exam? _____
- ☐ Previous orthodontic treatment, when? _____
- ☐ Experiencing orthodontic relapse relapse
- ☐ Previous cervical headgear
- ☐ Previous expansion completed, when? _____
- ☐ Expansion recommended
- ☐ High, narrow palate
- ☐ Dental crowding
- ☐ Permanent teeth extracted (other than wisdom teeth)
- ☐ Wisdom teeth extracted
- ☐ Using an oral appliance:
- ☐ Tongue crib or past habit corrector
- ☐ Past jaw surgery, when? _____
- ☐ Recommended jaw surgery _____
- ☐ High decay rate
- ☐ Can't reach the back molars with the tip of the tongue
- ☐ Small, recessed jaw

Speech

- ☐ History of speech therapy
- ☐ Trouble with certain sounds, what? _____
- ☐ Difficulty speaking fast
- ☐ Speech delay
- ☐ Stuttering / mumbling
- ☐ Trouble projecting voice

TMJ / TMD

- ☐ TMJ treatment past
- ☐ TMJ treatment current
- ☐ Very strong pain
- ☐ Intense, throbbing
- ☐ Moderate pain
- ☐ Mild pain
- ☐ Paresthesia
- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Acute inflammation (less than 2 weeks)
- ☐ Chronic inflammation (longterm, ongoing)
- ☐ Sharp and localized pain
- ☐ Pain on movement
- ☐ Pain reduced with rest
- ☐ Dull ache
- ☐ Diffuse (spread out) pan/ache
- ☐ Stiffness
- ☐ Deep ache, often at rest
- ☐ Inconsistent, variable pain
- ☐ Tenderness of the skin in area of pain
- ☐ "Knife-like" pain symptoms

Sleep

- ☐ Quiet sleeping at night with mouth closed, lips sealed
- ☐ Occasional snoring
- ☐ Frequent, snoring/loud breathing > 3 nights per week
- ☐ Loud snoring can be heard through a wall or door
- ☐ Has anyone ever reported that you occasionally gasp or stop breathing?
- ☐ Sleep in strange positions
- ☐ Wakes easily or often
- ☐ Prolonged bedwetting
- ☐ Wakes tired and not refreshed
- ☐ Restless sleeping
- ☐ Tooth grinding/clenching
- ☐ Grinding appliance
- ☐ Sleeps with mouth open
- ☐ Sleep apnea test taken, when? _____
- ☐ Previous sleep-disordered breathing diagnosed, when and what? _____
- ☐ Fatigue/daytime drowsiness
- ☐ Snoring appliance
- ☐ Frequent urination
- ☐ Night terrors
- ☐ Night sweats
- ☐ Wakes with headache
- ☐ Mouth taping at night?
- ☐ Sleep aid/CBD/melatonin at night?
- ☐ Are you male with a collar size > 17 inches?
- ☐ Are you female with a collar size > 16 inches?
- ☐ BMI greater than 30
- ☐ Being treated for hypertension
- ☐ Being treated for diabetes
- ☐ Being treated for heart disease
- ☐ Being treated for Alzheimer's/ dementia
- ☐ Being treated for anxiety
- ☐ Being treated for depression
- ☐ Being treated for chronic pain

Behavior Challenges / Stress

- ☐ Sensory processing
- ☐ Oppositional defiance
- ☐ Hyperactivity / Inattention
- ☐ Average stress level in last month (10 high, 1 low) _____
- ☐ Other:

Head / Neck / Tension (Adults)

- ☐ Frequent headaches
- ☐ Jaw / facial pain / tension
- ☐ Clenching / grinding
- ☐ Neck tension / pain
- ☐ Shoulder tension
- ☐ Forward head posture
- ☐ Slouching

Medical Conditions & Medications

Who Else is On Your Healthcare Team? (Chiro, massage therapist, physical therapist, myofacial release, etc)

Any Additional Information

Patient Name: _____ DOB: _____ Date: _____

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never dose
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0-3)**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place --- for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
	Total Score:			

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness. A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Patient Name: _____ DOB: _____ Date: _____

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

● A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.

● It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire

During the past week, I have found that:	**Disagree ← → Agree**						
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
					Total Score:		

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your score.

The fatigue Severity Scale key

A total score of less than 36 suggests that you may not be suffering from fatigue.
A total score of 36 or more suggests that you may need further evaluation by a physician.

Your next steps

This scale should not be used to make your own diagnosis.
If your score is 36 or more, please share this information with your physician. Be sure to describe all your symptoms as clearly as possible to aid in your diagnosis and treatment.

Name_____ Date_____

Sleep Quality Assessment (PSQI)

What is PSQI, and what is it measuring?

The Pittsburgh Sleep Quality Index (PSQI) is an effective instrument used to measure the quality and patterns of sleep in adults. It differentiates "poor" from "good" sleep quality by measuring seven areas (components): subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medications, and daytime dysfunction over the last month.

INSTRUCTIONS:

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month,

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. What time have you usually gotten up in the morning? _____
4. A. How many hours of actual sleep did you get at night? _____
   B. How many hours were you in bed? _____

5. During the past month, how often have you had trouble sleeping because you	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
A. Cannot get to sleep within 30 minutes				
B. Wake up in the middle of the night or early morning				
C. Have to get up to use the bathroom				
D. Cannot breathe comfortably				
E. Cough or snore loudly				
F. Feel too cold				
G. Feel too hot				
H. Have bad dreams				
I. Have pain				
J. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason (s):				
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
9. During the past month, how would you rate your sleep quality overall?	Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)

Scoring

Component 1 #9 Score C1 _____

Component 2 #2 Score (<15min (0), 16-30min (1), 31-60 min (2), >60min (3))
+ #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3) C2 _____

Component 3 #4 Score (>7(0), 6-7 (1), 5-6 (2), <5 (3) C3 _____

Component 4 (total # of hours asleep) / (total # of hours in bed) x 100
>85%=0, 75%-84%=!, 65%-74%=2, <65%=3 C4 _____

Component 5 # sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3) C5 _____

Component 6 #6 Score C6 _____

Component 7 #7 Score + #8 score (0=0; 1-2=1; 3-4=2; 5-6=3) C7 _____

Add the seven component scores together _____ ***Global PSQI*** _____

A total score of "5" or greater is indicative of poor sleep quality.
If you scored "5" or more it is suggested that you discuss your sleep habits with a healthcare provider

Quality of Life Scores:
These are common issues rated on a 1 (no problem) to 10 (significant problem) scale.

Please enter today's date at the top, and then please rate each box in that column with a number between 1 and 10 based upon what your experience is.

10 means it is a significant problem, 1 means there is not a problem.

Date				
...breathing through the nose. (congestion, colds, earaches, swollen tonsils, infections)				
...keeping lips together at rest (open mouth, lips apart at rest, chapped lips)				
...chewing & swallowing (uses face muscles, sloppy, noisy, quickly, drooling, tongue-tie)				
...sitting and standing with good posture (slouching, forward head, aches or pains)				
...eating and nutrition (picky, difficulty chewing, not nutritious, digestive issues)				
...daytime breathing (asthma, allergies to food, pollen, animals, toxins, parasites)				
...getting a good night's sleep (restless, snoring, messing bed, awakening, accidents)				
...breathing while sleeping (snoring, heavy breathing, open mouth)				
...body aches or pains (jaw aches, headaches, migraines, neck or back pain)				
...behavioral issues at home or in school (attention, learning, hyper, sleepy, spectrum)				

SLEEP HYGIENE INDEX (SHI)

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale to make your choice.

0	1	2	3	4
Never	Rarely	sometimes	Frequent	Always

1. I take daytime naps lasting two or more hours.	0 1 2 3 4	_____
2. I go to bed at different times from day to day.	0 1 2 3 4	_____
3. I get out of bed at different times from day to day.	0 1 2 3 4	_____
4. I exercise to the point of sweating within 1 hr of going to bed.	0 1 2 3 4	_____
5. I stay in bed longer than I should two or three times a week.	0 1 2 3 4	_____
6. I use alcohol, tobacco, or caffeine within 4hrs of going to bed or after going to bed.	0 1 2 3 4	_____
7. I do something that may wake me up before bedtime (for example: play video games, use the internet, or clean).	0 1 2 3 4	_____
8. I go to bed feeling stressed, angry, upset, or nervous.	0 1 2 3 4	_____
9. I use my bed for things other than sleeping or sex (for example: watch television, read, eat, or study).	0 1 2 3 4	_____
10. I sleep on an uncomfortable bed (for example: poor mattress or pillow, too much or not enough blankets).	0 1 2 3 4	_____
11. I sleep in an uncomfortable bedroom (for example: too bright, too stuffy, too hot, too cold, or too noisy).	0 1 2 3 4	_____
12. I do important work before bedtime (for example: pay bills, schedule, or study).	0 1 2 3 4	_____
13. I think, plan, or worry when I am in bed.	0 1 2 3 4	_____

Total score =_____

Pediatric Sleep Questionnaire

(Screening)

Name of the child:_____ Date of birth:_____

Person completing this form: _____

Date that you are completing the questionnaire: _____

Instructions: Please answer the questions about how your child **IN THE PAST MONTH**. Circle the correct response or *print* your answers in the space provided. "Y" means "yes," "N" means "no," and "DK" means "don't know." For this questionnaire, the word "usually" means "more than half the time" or "on more than half the nights."

Please answer the following questions as they pertain to your child <u>in the past month</u>.

		YES	NO	Don't Know
1.	**While sleeping, does your child:**			
	Snore more than half the time?	Y	N	DK
	Always snore?	Y	N	DK
	Snore loudly?	Y	N	DK
	Have "heavy" or loud breathing?	Y	N	DK
	Have trouble breathing, or struggle to breath?	Y	N	DK
2.	**Have you ever seen your child stop breathing during the night?**	Y	N	DK
3.	**Does your child:**			
	Tend to breathe through the mouth during the day?	Y	N	DK
	Have a dry mouth on waking up in the morning?	Y	N	DK
	Occasionally wet the bed?	Y	N	DK
4.	**Does your child:**			
	Wake up feeling unrefreshed in the morning?	Y	N	DK
	Have a problem with sleepiness during the day?	Y	N	DK
5.	**Has a teacher or other supervisor commented that your child appears sleepy during the day?**	Y	N	DK
6.	**Is it hard to wake your child up in the morning?**	Y	N	DK
7.	**Does your child wake up with headaches in the morning?**	Y	N	DK
8.	**Did your child stop growing at a normal rate at any time since birth?**	Y	N	DK
9.	**Is your child overweight?**	Y	N	DK
10.	**This child often:**			
	Does not seem to listen when spoken to directly.....	Y	N	DK
	Has difficulty organizing tasks and activities.....	Y	N	DK
	Is easily distracted by extraneous stimuli	Y	N	DK
	Fidgets with hands or feet, or squirms in seat	Y	N	DK
	Is "on the go" or often acts as if "driven by a motor"	Y	N	DK
	Interrupts or intrudes on others (eg butts into conversations or games)	Y	N	DK

Thanks!

Thank you for your careful completion of all the necessary information! We look forward to welcoming you to the Impact Health Solutions™ family!

See you soon!

Well and take care of you,

Carmen