Patient Form

Doctor/Dentist:

Patient's Name: _____

Relationship to Patient: _____

____ DOB: _____ Pediatrician:

Age: _____

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Sleep Disordered Breathing Questionnaire for Children Earl O. Bergersen, DDS, MSD

Please indicate to what degree your child exhibits any of the following symptoms using the scale of severity below. The initial score column should be evaluated and dated at first appointment and the follow-up score column should be evaluated and dated after 3 months of treatment by the same person who filled out the initial assessment.

| INITIAL SCORE FOLLOW-UP SCORE |
|--|
| Falls asleep watching TV Wakes up at night Attention deficit Restless sleep Grinds teeth Frequent throat infections Frequent ear infections Feels sleepy and/or irritable during the day |
| Wakes up at night Attention deficit Restless sleep Grinds teeth Frequent throat infections Frequent ear infections Feels sleepy and/or irritable during the day |
| Has a difficult time listening and often interrupts Fidgets with hands or does not sit quietly*: Muscular tics Restless (wiggles) legs Ever wets the bed Exhibits bluish color at night or during the day Nightmares and/or night terrors Exhibits any of the following*: Rarely smiles Feels sad Feels depressed Speech problems** **If scored greater than 0, please continue to Speech Questionnaire on page 2 (reverse side) |
| |

Was the reason for coming to this doctor for SLEEP or DENTAL issues? _____

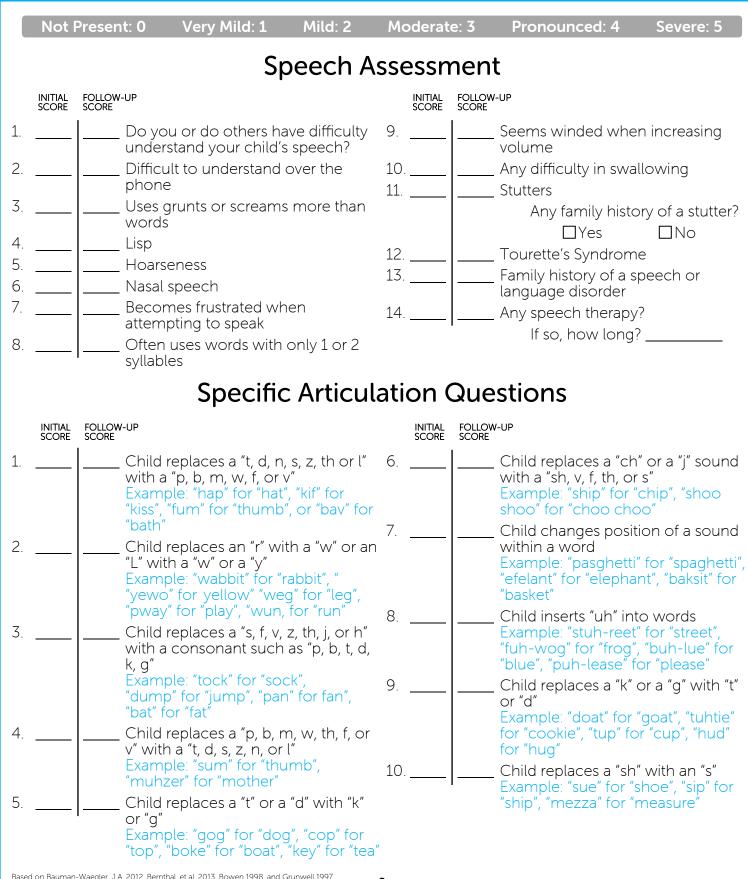
Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010 © by Ortho-Tain[®], Inc. 2019

Patient Form

Continued from question #30 on reverse side

Speech Questionnaire for Children

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Based on Bauman-Waegler, J.A. 2012, Bernthal, et al. 2013, Bowen 1998, and Grunwell 1997 © by Ortho-Tain[®], Inc. 2019 2