TEEN INFORMATION FORM

CASE NUMBER	**Click here to enter your answer...**
OPEN DATE	**Enter answer**
CLOSE DATE	**Enter answer**
PRACTITIONER	**Enter answer**

Name: Click here to enter your answer...

Date of Birth: Click here to enter your answer...

Parents Names: Click here to enter your answer...

Address & Post Code: Click here to enter your answer...

Phone Number: Click here to enter your answer...

Please answer the questions honestly. Each sleep programme we write is unique to you. Your details are kept confidential and details are not passed on to any other person.

Why do you want help with your sleep problem?

Click here to enter your answer...

TEEN INFORMATION FORM

BACKGROUND INFORMATION

1. **Who lives in your family home?**

Click here to enter your answer...

2. **When did the sleep problem start**

Click here to enter your answer...

3. **Have you ever visited the doctor or other professionals to discuss this sleep problem/ behaviour prior to contacting us? If yes could you tell us who?**

Click here to enter your answer...

4. **What do you see the problem being e.g. difficulty falling asleep, waking in the night, difficult getting up in the morning?**

Click here to enter your answer...

5. **Are you sleepy during the day?**

Click here to enter your answer...

6. **Do you ever take a nap in the day? If so how long for?**

Click here to enter your answer...

7. **Do you have any medical needs we needs or take any medication?**

Click here to enter your answer...

TEEN INFORMATION FORM

YOUR HOME

1. Describe your bedroom. Note the following:

- Double bed, single bed?
- Is there TV, video, computer equipment in the room?
- Are there blackout blinds?
- Do you share it with any siblings?
- Is their bedroom upstairs?

Click here to enter your answer...

2. Is your bathroom upstairs?

Click here to enter your answer...

3. Do you take a bath or shower at night time? If so when

Click here to enter your answer...

TEEN INFORMATION FORM

EVENING TIME

Can you describe what happens from 7pm onwards e.g. when you eat, how you spend your time up until going to bed.

Click here to enter your answer...

TEEN INFORMATION FORM

GOING TO SLEEP

1. **Do you go to sleep with the lights off?**

Click here to enter your answer...

2. **Do you fall asleep watching TV or playing music?**

Click here to enter your answer...

3. **What time do you generally fall asleep?**

Click here to enter your answer...

4. **How long does it take you to go to sleep?**

Click here to enter your answer...

5. **How many hours in total do you think you sleep each night?**

Click here to enter your answer...

DURING THE NIGHT

1. **Do you wake up during the night? If so, how often?**

Click here to enter your answer...

2. **How long does it take you to go back to sleep?**

Click here to enter your answer...

3. **What do you do when you wake up?**

Click here to enter your answer...

IN THE MORNING

1. **What time do you wake up in the morning when it is a school day?**

Click here to enter your answer...

2. **What time do you wake up at the weekend?**

Click here to enter your answer...

3. **How do you feel when you wake up?**

Click here to enter your answer...

Is there anything else you think we should know about your sleep problems?

Click here to enter your answer...