

Home Study Assessment for Childhood Sleep Problems

Childhood Sleep Disordered Breathing has many “signs and symptoms” that relate to medical health, behavioral health, mental health, and dental health. Many of these are associated with quality of sleep, airway development, jaw development, general behavior & mental development, and general health.

INSTRUCTIONS:

By looking for and noticing these signs and symptoms, you can gain a better picture of your child’s overall health. When observing for signs and symptoms, some items may be easily identified and others may require observing at various times of day/night, and in different settings or situations. It’s best to do this without your child knowing you are watching so that you can accurately observe behaviors, postures, and activities in their natural setting or presentation.

Print this Home Study and check all conditions that apply. If in doubt, check it! Please bring this completed Home Study with you.

Child Name: _____

While Sitting Around... (watching TV, riding in car, etc.) Does your child:

- Put “things” in the mouth a lot (i.e. chew/suck on toys, sleeves, shirt collars, pencils, fingernails)
- Lick lips often – chapped lips
- Hold lips apart or ‘hang’ with mouth open during day
- Breath with mouth open – even a little bit
- Stick, thrust or dart the tongue out of the mouth
- Have the tongue resting between the teeth (resting teeth on tongue or biting lips)
- Lean the check on a hand
- Make noises when breathing

While Talking... Does your child:

- Talk very fast or talk very slow
- Gasp for air when speaking
- Speak with a lisp
- Take speech lessons

While Eating... Does your child:

- Gasp for air while eating/chewing
- Stick tongue between teeth when swallowing
- Stick tongue out to meet the drinking glass rim
- Drink a lot while eating
- Make noises when chewing
- Eat sloppily
- Take a breath before drinking
- Puff cheeks out when drinking
- Mash lips together or ‘purse’ when swallowing water or food
- Make the chin “crinkle” or tighten when swallowing
- Bob the head when swallowing
- Have trouble sitting still

While Sleeping... Does your child:

- Sleep or breathe with mouth open – lips not touching
- Snore or have ‘noisy-breath’ breathing
- Wet the bed
- Tilt the head back
- Wake up frequently
- Have restless sleep
- Have nightmares / night terrors
- Grind the teeth
- Have hard time waking up
- Wake up tired
- Have abnormal sleep issues

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Medical History & Symptoms... Does your child have or complain of:

- | | |
|---|--|
| <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Sore throat / throat infections |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck aches |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Dry or chapped lips |
| <input type="checkbox"/> Ringing ears or dizziness | <input type="checkbox"/> Trouble swallowing pills |
| <input type="checkbox"/> Tubes in ear drums | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stuffy or itchy ears | <input type="checkbox"/> Tonsils and/or Adenoids removed |
| <input type="checkbox"/> Runny nose or sinus problems | <input type="checkbox"/> Take medications for ADD/ADHD |

Does your child:

- Use a pacifier - Until age _____.
- Suck finger(s) or thumb

Behavioral Symptoms... Does your child:

- | | |
|---|---|
| <input type="checkbox"/> Have ADD/ADHD | <input type="checkbox"/> Have problems with paying attention |
| <input type="checkbox"/> Have bouts of aggression, defiance or social discord | <input type="checkbox"/> Have difficulty sitting still |
| <input type="checkbox"/> Have trouble with school work and learning | <input type="checkbox"/> Fidget with hands, constant movement |

As a baby was your child:

- | | |
|--|---|
| <input type="checkbox"/> Breast fed or bottle fed | <input type="checkbox"/> Hard to feed |
| If breast fed, how long: _____ | <input type="checkbox"/> Refusing to chew food |
| <input type="checkbox"/> Early or late getting teeth | <input type="checkbox"/> Prone to ear infection |

Family Health History... Do YOU (i.e. the child's parents) have, or have you had:

- | | |
|---|---|
| <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Frequent infections, allergies or asthma |
| <input type="checkbox"/> Orthodontic braces | <input type="checkbox"/> TMJ or jaw problems |
| <input type="checkbox"/> Tooth extractions for braces | <input type="checkbox"/> Sleep apnea or sleep problems |
| <input type="checkbox"/> Ear problems | |

When you observe your child do they have any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Overbite or over-jet or forward positioned front teeth | <input type="checkbox"/> Teeth wear from grinding teeth |
| <input type="checkbox"/> Convex or concave facial profile - recessed chin or shallow mid-face | <input type="checkbox"/> Open bite from finger/thumb sucking |
| <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Strained or tense chin muscles when swallowing |
| <input type="checkbox"/> Forward head posture | <input type="checkbox"/> Tongue thrust – tongue between teeth when swallowing |
| <input type="checkbox"/> Slouching general posture | <input type="checkbox"/> Dark circles under eyes |
| <input type="checkbox"/> Narrow arch – high vaulting palate | <input type="checkbox"/> Tooth wear |
| <input type="checkbox"/> Tongue tied | |

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