Rocky Mountain Pediatric Neurology & Sleep Medicine

Sleep Packet

Patient Demographics – Page 1

Appointment Date: _____ **Location:** Denver | Lonetree | Colorado Springs | Grand Junction | Gillette

Patient Information

Patient First Name:		Last Name:	
Nickname: Language Preference:	Race: ___ White ___ Black or African American ___ American Indian or Alaska Native ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Refuse to Report	Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___ Refuse to Report	
Date of Birth:	**SSN:**	Male ☐	Female ☐
Address:	City:	State:	Zip:
Primary Contact Phone:		Name/Relation to patient at this number:	
Primary Email Address**:**			
Secondary Contact Phone:		Name/Relation to patient at this number:	
Emergency Contact Name:	Phone:	Relationship to Patient:	

Parent / Guardian Information – Financial Responsibility

Primary Guarantor's Name:	SS#:	DOB:	
Relationship to Patient: ☐Father ☐Mother ☐Step-Father ☐Step-Mother ☐Legal Guardian			
Address:	City	State:	Zip:
Cell Phone:	Employer / Occupation:		
Home Phone:	Work Phone:		
Secondary Guarantor's Name:	SS#:	DOB:	
Relationship to Patient: ☐Father ☐Mother ☐Step-Father ☐Step-Mother ☐Legal Guardian			
Address:	City	State:	Zip
Cell Phone:	Employer / Occupation		

Primary Care Physician – Referring Physician

Practice Name	Physician Name		
Phone:	Fax		
Address	City	State	Zip

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Patient Demographics – Page 2

Insurance Information			
Primary Insurance Company		**Secondary** Insurance Company	
Insurance Address		Insurance Address	
ID#		ID#	
Group # or Name		Group # or Name	
Subscriber Name		Subscriber Name	
Subscriber DOB		Subscriber DOB	
Relationship to Patient		Relationship to Patient	
Employer		Employer	

How can we contact you?				
Type of call	**Name**	**Phone number**	**OK to leave a message?**	
			YES	**NO**
Appointment Reminders:	#1			
	#2			
Medical Information:	#1			
	#2			
Written Communication:	Name:	Full Address (if different from 1st page):		

Pharmacy Information		
Name:	Phone:	City (or cross streets):

How did you hear about us?		
☐ Family / Friends?	☐ Insurance Directory?	☐ Other Physician Listing?
☐ Online research? If yes, what website(s) led you to us?		
☐ Other (please note who, so we know who to thank)		

We bill directly to your insurance as a courtesy to you. However, it is your responsibility to understand your benefits, and eligibility. You are ultimately responsible for payment if your visit is not covered. If you need further information, please contact your insurance carrier directly using the customer service phone number on the back of your card. Please be prepared to make payment or co-payment at the time of service.

By signing below I affirm that all information above is true and correct to the best of my knowledge.

Patient (or Patient Representative) Signature *Today's Date*

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Proxy for Minor Patients 12-17 Years of Age
Express Waiver and Consent

The undersigned patient ('Patient") hereby grants to the undersigned parent or legal guardian of Patient ("Parent"), and Parent hereby requests to be granted, proxy access to Patient's health and other information ("Patient Information") and understand that by doing so Patient waives all rights related to privacy and confidentiality of Patient Information with Parent including, without limitation, the privacy practices of[the practice]. . Patient represents and warrants that he or she is a minor with the ability to enter into agreements relating to the consent to access and waiver of rights involving highly sensitive medical data. This consent is effective unless otherwise prohibited by state law. Parent represents and warrants that he or she is the parent or legal guardian of the minor patient with the ability to enter into agreements relating to the consent to access and waiver of rights involving Patient's medical data. Patient and Parent further understand and acknowledge that (a) [the practice] can rely on this waiver and consent until revoked by either Patient or Parent in writing, or until the patient reaches 18 years of age, at which point the account will automatically terminate for both patient and proxy; (b) by providing this waiver and consent Parent has no fewer rights to access Patient Information than Patient has, including to all communications between [the practice] and the patient and/or parent; and (c) Patient and Parent waive all rights and remedies relating to Parent's use or misuse of Patient or other information communicated between patient and [the practice] pursuant to this Express Waiver and Consent. Please note that if this waiver and consent is revoked, such revocation will not affect any action taken in reliance on this waiver and consent prior to such revocation. If either Patient or Parent desires to revoke this Proxy Express Waiver and Consent, he or she must call Patient Portal Support at 1-855-870-5350. Proxy access will automatically terminate for both Patient and Parent when the Patient reaches 18 years of age. Patient may then re-apply for access as an adult.

Patient and Parent Information	
Patient Name (print):	**Patient/Authorized Patient Representative Signature:**
Medical Record Number:	**Date of Birth:**
Date of Consent:	**Last 4 of SSN:**
Parent or Legal Guardian Name (print):	**Parent or Legal Guardian Signature:**
Parent Email Address:	

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Initial Sleep History Form

For Office Use Only: Primary Ins: _____ Secondary Ins: _____

Patient Name:	Date of Birth:
Nickname:	Primary Care Physician:
Chief Complaint (Reason for Visit)	

Medications [ ] None

Current medications:	
Medication:	Dosage and Frequency:
Medication:	Dosage and Frequency:
Medication:	Dosage and Frequency:
Medication:	Dosage and Frequency:
Previous medications related to the reason you are here:	
Medication:	Dosage and Frequency:
Medication:	Dosage and Frequency:
Medication:	Dosage and Frequency:

Drug Allergies [ ] None

Drug:	Reaction:
Drug:	Reaction:
Drug:	Reaction:

Immunizations up to date? Y / N **Have you received the Flu Vaccine?** Y/N **If Yes, When? _____**

Patient's Medical History

Chronic Medical Conditions:

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Birth History

Complications with Birth? Y / N	If yes, describe:
Delivery via C-section? Y / N	If yes, why?
Born on time? Y / N	If no, how many weeks?
Other complications with Delivery? Y / N	If yes, describe:
Problems after Birth? Y / N	If yes, describe:
Age at discharge:	Birth weight:

Surgeries [ ] None

Age:	Operation:
Age:	Operation:
Age:	Operation:

Hospitalizations [ ] None

Age:	Reason:
Age:	Reason:
Age:	Reason:

Family History (please list all known family history)

Mother: Name	Age:	Health Information:
Father: Name	Age:	Health Information:
Sibling: Name	Age:	Health Information:
Sibling: Name	Age:	Health Information:

Are there any family members who have or had any of the following conditions (please circle all that apply)? [] NO

Seizures/epilepsy, developmental delay, mental retardation, learning disability, cerebral palsy, multiple sclerosis, stroke, muscular dystrophy, headache/migraine, tremor, tics, ADHD, autism, depression, schizophrenia, other neurologic disease or psychiatric disease

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Social History

Who lives at home?		
Alcohol, drug or tobacco use in home? **Parents** **Patient** **N/A**		
Year in school:	Average grades:	Grades repeated:
What do you want to be when you grow up?		

Developmental History (Check box ONLY if they were delayed. Please indicate age)

Smile		Roll B to F		Pincer Grasp	
Laugh		Roll F to B		Scribble	
1st Word		Sit		Bladder Control	
2-3 Word Phrases		Crawl		Bowel Control	
Head Control		Walk		Ride a Bicycle	
Any history of Developmental Regression (Loss of Previously Acquired Skills)? Y / N					

Review of Systems (Please make an 'X' next to RECENT SYMPTOMS) [ ] None

Constitutional:---→	*Fever*	*Weight Change*	*Sleep Disturbance*
Allergic/Immunologic :->	*Frequent Infections*	*Food Allergies*	
Skin:→	*Rash*	*Birth Mark*	*Moles*
Eyes:-→	*Blurry Vision*	*Double Vision*	*Pain*
Ears, Nose, Throat: →	*Hearing Loss*	*Congestion*	*Sore Throat*
Respiratory:-→	*Shortness of Breath*	*Cough*	*Wheezing*
Cardiovascular:-→	*Chest Pain*	*Palpitations*	*Fainting*
Gastrointestinal:→	*Vomiting*	*Diarrhea*	*Abdominal Pain*
Genitourinary:→	*Incontinence*	*Pain*	*Change in Frequency*
Musculoskeletal:-→	*Joint Pain*	*Pain or Cramps*	*Weakness*
Neurological:-→	*Headaches*	*Numbness*	*Tremors*
Psychiatric:-→	*Depression*	*Anxiety*	*ADHD*
Hematologic: -→	*Abnormal Bleeding*	*Easy Bruising*	*Anemia*
Endocrine:--→	*Excessive Sweating*	*Loss of Energy*	*Cold Intolerance*

Have you been feeling "down", "depressed" or "hopeless" within the last two weeks? Y/N
Do you do any activities (i.e. sports, crafts, clubs, horseback riding, etc.) that you enjoy?

Sleep History

What concerns do you have about your child's sleep?
What have you tried to help with your child's sleep problems?
Please describe your child's bedtime routine:

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Sleep History Continued:

Bedtime on:	Weekdays	Weekends/Vacation
Wake time on:	Weekdays	Weekends/Vacation
Does your child have his/her own room?		
Does your child have his/her own bed?		
Is a parent present when the child falls asleep?		
Does your child take naps?	If so, what time? For how long? How many days per week?	
Does your child resist going to bed?		
Does your child have difficulty falling asleep?		
Does your child awaken at night?	If so what do you think awakens him/her? If he/she awakens is there difficulty falling back asleep?	
Is your child difficult to awaken in the morning?		
Do you feel your child is a poor sleeper?		

Please check any of the following that apply to your Child [ ] None

Difficulty Breathing when asleep	*Stops breathing during sleep*	*Snores*
Choking in sleep	*Restless sleep*	*Sweating while sleeping*
Daytime Sleepiness	*Poor appetite*	*Nightmares*
Sleepwalking	*Sleep talking*	*Screaming in sleep*
Kicks legs in sleep	*Grinding teeth in sleep*	*Bed wetting*
Resists going to bed at bedtime	*Gets out of bed at night*	*Trouble getting up in the morning*
Falls asleep at school	*Naps after school*	*Gasping/pausing in breathing during sleep*
Uncomfortable or creepy crawly feeling in legs at night	*Reports unable to move when falling asleep or upon awakening*	*Sees frightening visual images before falling asleep or upon wakening*
Feels week or loses control of muscles with strong emotions		

Additional Information You Think May Be Helpful

Specific Questions

Signature	**Relationship**	**Date**