**Sleep Diary/Questionnaire**

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| **Date:** |  |
| **Name of parent/s:** |  |
| **Name of child:** |  |
| **Date of birth:** |  |
| **Names and ages of siblings:** |  |
| **Phone number or skype ID** |  |

Please confirm you have read the terms and conditions:

Where did you hear about Feed Sleep Bond?

Are you aware that I do not use any controlled crying, cry it out, or other intensive crying to sleep techniques?

Whilst I never prescribe crying to sleep techniques, are you aware that sometimes children will cry when they do not get the same sleep strategy that they have had up till now, although this will never be on their own?

Are you ready and willing to make changes? Are you planning to be home for the next few weeks and be consistent and patient with your child’s sleep plan?

How would you like to speak to me? Zoom/Phone

What day would you prefer to speak?

What time of day would you prefer?

Is there anything you would like me to be aware of to help me to be respectful to you and your family?

**Background history and health**

Do you have any significant health concerns in relation to your child? If yes, what:

Is your child taking any prescribed, over the counter, herbal or naturapathic medicines?

Is your child taking any vitamin or mineral supplements?

Who looks after your child during the day?

Are there any concerns regarding your child’s weight?

Does your child have any skin problems – such as dry skin, eczema or rashes?

Does your child have a history of tongue tie?

Does your child regularly mouth breathe/snore/have noisy breathing?

Your child’s stool pattern: How frequently do they open their bowels, and what colour/consistency? (Sorry for unpleasant question!)

(If applicable): Is your child breast or formula fed?

Does your child have a dummy/pacifier?

Did you have any complications at birth?

How was your child born? (Caesarean, ventouse, forceps, unassisted vaginal delivery)

Is there a family history of allergy, food intolerance, eczema or asthma?

Is your child currently seeing any other health care professional or alternative/complementary therapist? Please specify:

**Your current sleep situation**

How do you get your child to fall asleep currently?

Do you have a bedtime routine? If yes, what do you do?

Where does your child sleep (your bed, crib, cot, toddler bed etc)?

Is there anything you definitely **do not** want to change?

Is there something you definitely want to change that you’d like us to prioritise?

How would you describe your parenting style?

How would you scale your current sleep situation?

1. I just need some reassurance
2. I know my child's sleep is normal, but I'm beginning to struggle and need some support. I do not really feel I need to change my child's sleep, it's more how I manage on a day to day basis
3. I'm beginning to find my child's sleep problematic, and need to find some ways to make it easier. I am prepared to make some changes, but do not feel this is an emergency situation, and I can take my time.
4. I am in a sleep crisis. I feel like I cannot go on much longer, and urgently need to make some changes. I may not know where to start, and I may not have the capacity for anything that results in even less sleep, but I definitely need to make some big changes in order to cope.

**Food, feeds and eating**

Please let me know about anything relevant to your child’s diet or nutritional status. If your baby is exclusively milk fed please don’t worry about telling me about timings – I encourage responsive, cue-based feeding.

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| **Please write down your child’s *approx* feed/meal times in 24 hours** | **Is your child generally a good eater/feeder?** |
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**Your main sleep concerns**

Please tell me if you have any particular concerns about your child’s sleep. You can write as much or as little as you like.

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| **Please give a brief overview of your child’s sleep problem/issue and what methods (if any) you have tried so far to alleviate this.**  **Please explain how the problem/issue affects you, your child and the rest of the family.** |
| **Naps:**  **Settling to sleep:**  **Middle of the night:**  **Daytime behaviour:**  **Early rising?**  **Effect on the family:**  **Tried so far:** |

**Your specific sleep goals**

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| **Please detail what your goals are regarding your child’s sleep.** |
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**DIARY**

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|  | **Day:** | **Day:** |
| **Time woke in morning** |  |  |
| **Time & length of nap(s) in day** |  |  |
| **Time start preparation for bed in evening** |  |  |
| **Time went to bed in evening** |  |  |
| **Who put him/her to bed** |  |  |
| **Time went to sleep** |  |  |
| **Time(s) woke up in night** |  |  |
| **What happened and what did you do** |  |  |
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| **Please add anything else you feel is relevant in your situation.** |
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