

Holistic Family Wellness Assessment

Sherri Morris - Family Sleep Support

Personal Information

Parent name

Profession

Parent name

Profession

Address

Email

Phone number

How did you hear about me

Family History

Is there a family history of sleep disorders? If yes, please provide details.

-

Is there any family history of food sensitivities? If yes please provide details.

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Has the birthing parent ever been iron deficient? When was the last time you had your iron checked?

-

Did the birthing parent have gestational diabetes?

-

Are you feeling any pressure about your parenting choices from people around you?

-

Child's information

Child's name

Child's birthdate/age. Was the child born at term or premature?

-

Do you have other children? Names and ages?

-

Child's medical history

Describe your child's birth.

-

What is the overall health of your child? Are they often sick?

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Are there any health concerns or allergies I should be aware of? Does your child have any chemical or food sensitivities? Have you discussed this with your pediatrician?

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Does your child have eczema or frequent skin rashes?

-

Does your child have reflux?

-

Is your child taking any medications or supplements? If yes, please list.

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Does your child see any other practitioners in addition to their primary care provider? (ie. Chiropractor, naturopath, therapists)

-

Is your child currently sick or recovering from illness?

-

Is your child teething?

-

Child's sleep

Please highlight any that apply:

My child:

Wakes suddenly with colicky-type abdominal pain

Takes pauses in their breathing while sleeping

Restless at bedtime

Restless while sleeping

Has chronic congestion and gasps or wheezes

Excessive gas and abdominal swelling

Gags or chokes during the night

Labeled colicky

Snores

Mouth breathes while sleeping

Your parent gut tells you something could be physically wrong with your child affecting their sleep

Please highlight all that apply

Child sleeps:

In bassinet/crib

In their own bed

In parent's bed

In parent's room

Both in their own room and parent's room

Shares room with sibling

If child sleeps in more than one location, please give me an idea of when your child changes locations throughout the night. Does this occur every night? Some nights?

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Do you use white noise? If so how loud?

-

Does your child's sleep environment have any outside noise? (ie: loud street, creaky floors, loud sibling)

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What does your child sleep in? Is your child swaddled?

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Is the room your child sleeps in pitch black?

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Does your child use a lovey or pacifier?

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What is your naptime routine? Please describe what you do and how long it takes.

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What is your bedtime routine? Please describe what you do and how long it takes.

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Do you change your child's diaper during the night?

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If your child wakes at night do they fall back to sleep independently or do they need parental support to go back to sleep?

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If your child wakes at night what do you find is the best way to calm them other than feeding?

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Have you ever done sleep training? If yes please describe in detail the method, successes, how did your baby respond, how you responded, did you work with a sleep consultant?

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Child's Nutrition

Is/was your child breastfed, bottlefed breastmilk, formula fed? How long?

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If you breastfeed did you have any issues breastfeeding? Did you see a lactation consultant?

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If you are breastfeeding or bottlefeeding please highlight if you have noticed:

- A clicking noise when feeding
- Milk spilling out of the side of the mouth
- Gulping or choaking while feeding
- Quick, frequent feeds
- Child has been slow to gain weight or lost weight
- Pain while breastfeeding

Log your child's feeding for one day. Include start/end times for breast or bottlefeeds, if bottlefed how much was consumed, if solid foods log types of foods.

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Is your child eating solid food? At what age did your child start solids? What types of solids are you giving your child? Purees? Baby led weaning? Full table foods?

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If your child is older than 12 months have you noticed...

- Picky eating
- Gagging or choking on solid foods
- Speech or language delays

Are there any concerns about feeding you would like to share with me?

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Emotional Well Being

Is there anything else going on in your home that may be affecting your child? (ie. Parent arguments, new childcare situation, new baby, job change, move, vacations, etc)

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Is your child in any type of childcare? If yes do they seem to enjoy it?

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What is your child's activity level like throughout the day? Do they have time to play outside every day?

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Goals and Expectations

What are your top 2 priorities/goals for your child?

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What are your top 2 goals for the sleep support I offer?

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Sleep Log

Please log your child's sleep for 3 days.

	Morning wake	Naps (include time fell asleep and time they awoke)	Bedtime	Nighttime wakes (include time they awoke and time they fell back to sleep)
Day 1				
Day 2				
Day 3				

In these 3 days do you feel your child struggled with getting to sleep for naps or bedtime? How long did it take for you to get your child to sleep?

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Are there any other patterns or information that might be helpful for me to know that you noticed in these 3 days of logging your child's sleep?

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