![A picture containing text, outdoor, sign, tableware

Description automatically generated]()

Your name Click here to enter text.

DOB Click here to enter text.

Your address Click here to enter text.

Phone numberClick here to enter text.

Email Click here to enter text.

Your child’s name Click here to enter text.

DOB Click here to enter text.

Age Click here to enter text.

**Your child’s medical history**

Past medical or surgical problems

Click here to enter text.

Medications

Click here to enter text.

Allergies

Click here to enter text.

**Living arrangements**

Does your child have siblings? Yes  No

Please detail their names and ages

Click here to enter text.

**Is there another adult in the home helping you raise your child**?

Yes  No

Please detail that person/s name/s and role

Click here to enter text.

**Your child’s feeding history**

Is your child receiving breastmilk?

mostly from breast?  mostly from bottle?

If so, how often does he or she breastfeed during day?

Click here to enter text.

How often does he or she breastfeed during the night?

Click here to enter text.

What are your breastfeeding goals (including planned age of weaning)?

Click here to enter text.

Does your child take formula? Yes  No

If so, how often does he or she take a bottle during the day?

Click here to enter text.

How often does he or she take a bottle during the night?

Click here to enter text.

Please describe your child’s solids intake

Click here to enter text.

**Day-time sleep**

When does your child wake up to start the day?

Click here to enter text.

How many naps does your child have during the day on average?

Click here to enter text.

Please detail average duration

Click here to enter text.

How does your child fall asleep during the day?

Click here to enter text.

**Night-time sleep**

What time does your child go to bed for the night?

Click here to enter text.

How does your child fall asleep at bed-time?

Click here to enter text.

What time do you go to bed at night on average?

Click here to enter text.

How many times, if at all, does your child wake before you go to bed?

Click here to enter text.

How often does your child wake during the night?

Click here to enter text.

Roughly at what times?

Click here to enter text.

What do you do when your child wakes in the night?

Click here to enter text.

How long does it take you to tend to your child when he or she wakes in the night?

Click here to enter text.

How long does it take you to get back to sleep after that?

Click here to enter text.

**Please summarise the sleep challenge that you are facing**

Click here to enter text.

**Your values**

*There are no ‘right’ or ‘wrong’ values, and your values are unique to you. They are like the points on a compass – they guide the directions in which we want to travel. It is not necessary to fill this out but it could be helpful to spend a moment clarifying your overriding values, as you care for your family and*

*for yourself, and jotting your thoughts down here. You could do this by imagining your child is now celebrating his 21st birthday, and you are looking back to these early days: what kind of parent do you want to have been as you managed his or her night-waking in childhood?*

Click here to enter text.

**What do you hope to get out of this consultation?**

Click here to enter text.

