PEDIATRIC TM/AIRWAY-SLEEP SCREENING Form

PATIENT NAME:_____ **DATE:**_____

Please indicate if your child experiences any of the following:

- ☐ Snoring
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Restless Sleep
- ☐ Night Terrors
- ☐ Excessive Daytime Sleepiness
- ☐ Chronic Mouthbreathing
- ☐ Bed Wetting
- ☐ Dental Crowding
- ☐ Speech Difficulties
- ☐ History of Respiratory Infections (Ear, Nose, Throat)

Parent Signature: _____ Date: _____

FOR CLINICAL OFFICE USE:

JVA QUICK Completed: *Yes* ☐ *No* ☐ Openbite:_____ OB_____mm OJ _____mm

☐ Dental Crowding ☐ Frenum Pulls ☐ Narrow Arch Forms

Range Of Motion Measurements:

Lateral Excursion Right _____ mm Interincisal Opening (with pain) _____ mm

Lateral Excursion Left _____ mm Interincisal Opening (w/o pain) _____mm

Protrusive _____ mm

By: _____*(Initials)* **Date**:_____