

Child Sleep Questionnaire
(1 – 12 years of age)

Patient's Name: _____

Date of Birth: _____ Date: _____

Please describe your child's sleep problem(s): _____

How long has this been a problem? _____ Has the problem become worse? _____

What do you think is causing the sleep problem? _____

What have you previously tried to help this problem? _____

Sleep Habits:

Bedtime weekdays/school days _____ weekends/non-school days _____

Waketime weekdays/school days _____ weekends/non-school days _____

How long does it take to fall asleep? weekdays/school days _____

weekends/non-school _____

Number of days each week that the child takes a nap? _____

Typical nap times (from when to when): _____

General Sleep Information

Is there a regular bedtime routine? Yes No

If so, describe the routine: _____

Does your child have his/her own bedroom? Yes No

Does your child have his/her own bed? Yes No

Does your child resist going to bed? Yes No

Does your child have difficulty falling asleep? Yes No

Is there a parent present when your child falls asleep? Yes No

Does your child awaken during the night? Yes No

If so, does your child have difficulty returning to sleep? Yes No

Is your child difficult to awaken in the morning? Yes No

Current Sleep Symptoms:

Difficulty breathing when asleep? Never Occasionally Frequently

Stops breathing during sleep? Never Occasionally Frequently

Snores? Never Occasionally Frequently

Sweating during sleep? Never Occasionally Frequently

Nightmares? Never Occasionally Frequently

Sleepwalking? Never Occasionally Frequently

Sleeptalking? Never Occasionally Frequently

Screaming during sleep? Never Occasionally Frequently

Legs or arms moving during sleep? Never Occasionally Frequently

Waking up during the night? Never Occasionally Frequently

Getting out of bed during the night? Never Occasionally Frequently

Resistance going to bed? Never Occasionally Frequently

Teeth grinding? Never Occasionally Frequently

Uncomfortable feelings or pains in legs? Never Occasionally Frequently

Bed wetting? Never Occasionally Frequently

Rock head or body from side to side? Never Occasionally Frequently

Current Daytime Symptoms:

Trouble getting up in the morning?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Falls asleep at school?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Naps after school?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Daytime sleepiness?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Poor appetite?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Feels weak or loses control of muscles with strong emotions (anger, laughing)?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Reports being unable to move when falling asleep or upon awakening?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Reports frightening visual images before falling asleep?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently

Evening Routine:

Caffeinated beverages during day or evening? Yes No
If so, how many, type (cola, tea, coffee) and when? _____

Watch TV in bedroom or in bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use a computer in bedroom or in bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Listens to the radio in bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reads in bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Talks or texts on phone in bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medical History:

History of prematurity? Yes (how many weeks gestation _____) No

Drug allergies?

List allergies: _____

Food/ environmental allergies

List allergies: _____

Current Medications: _____

Current Medical Problems: _____

Previous surgeries: _____

Family Sleep History:

Does anyone in the family:

- | | | |
|-------------------------------|------------------------------|-----------------------------|
| Have Obstructive Sleep Apnea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have Restless Leg Syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have Narcolepsy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Mother's Age: _____

Father's Age: _____

Siblings:

Sisters' (age): _____

Brothers' (age): _____

EPWORTH SLEEPINESS SCALE SCORE

How likely is your child to doze off or fall asleep in the following situations, in contrast to feeling *just tired*?

This refers to your usual way of life in recent times. Even if you/ your child have not done some of these things recently, try to work out how they would affect you/ your child. Use the following scale to choose the most appropriate number for each situation.

- NO CHANCE OF DOZING 0
- SLIGHT CHANCE OF DOZING 1
- MODERATE CHANCE OF DOZING 2
- HIGH CHANCE OF DOZING 3

<u>SITUATION</u>	<i>CHANCE OF DOZING (0-3)</i>
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (e.g. movie theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon or after school	
Sitting and talking to someone	
Sitting quietly after lunch	
Doing homework or taking a test (if applicable)	