

Sleep Evaluation Questionnaire

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

CHILD'S INFORMATION	
Child's name:	Child's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's birthdate:	Child's age:
Child's racial/ethnic background:	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian-American <input type="checkbox"/> Native-American <input type="checkbox"/> Hispanic-Latino <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other

What are your major concerns about your child's sleep?

What things have you tried to help your child's problem?

SLEEP HISTORY	
Weekday Sleep Schedule	
Write in the amount of time child sleeps during a 24-hour period <u>on weekdays</u> (add daytime and nighttime sleep):	_____ hours _____ minutes
The child's usual <u>bedtime</u> on <u>weekday nights</u> :	_____ : _____
The child's usual <u>waketime</u> on <u>weekday mornings</u> :	_____ : _____



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After nighttime awakening, child has difficulty falling back to sleep?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child is difficult to awaken in the morning?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child is a poor sleeper?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no

Current Sleep Symptoms							
							(f) do not know
						(e) always (6 to 7 nights/days a week)	
					(d) often (3 to 5 nights/days a week)		
				(c) sometimes (1 to 2 nights/days a week)			
		(b) not often (less than 1 night/day a week)					
		(a) never (does not happen)					
1.	Difficulty breathing when asleep	a	b	c	d	e	f
2.	Stops breathing during sleep	a	b	c	d	e	f
3.	Snores	a	b	c	d	e	f
4.	Restless sleep	a	b	c	d	e	f
5.	Sweating when sleeping	a	b	c	d	e	f
6.	Daytime sleepiness	a	b	c	d	e	f
7.	Poor appetite	a	b	c	d	e	f
8.	Nightmares	a	b	c	d	e	f
9.	Sleepwalking	a	b	c	d	e	f
10.	Sleeptalking	a	b	c	d	e	f
11.	Screaming in his/her sleep	a	b	c	d	e	f
12.	Kicks legs in sleep	a	b	c	d	e	f
13.	Wakes up at night	a	b	c	d	e	f
14.	Gets out of bed at night	a	b	c	d	e	f
15.	Trouble staying in his/her bed	a	b	c	d	e	f
16.	Resists going to bed at bedtime	a	b	c	d	e	f
17.	Grinds his/her teeth	a	b	c	d	e	f
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19.	Wets bed	a	b	c	d	e	f



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Current Daytime Symptoms							
							(f) do not know
							(e) always (6 to 7 days a week)
						(d) often (3 to 5 days a week)	
					(c) sometimes (1 to 2 days a week)		
				(b) not often (less than 1 day a week)			
			(a) never (does not happen)				
1.	Trouble getting up in the morning	a	b		c		d
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f

PREGNANCY/ DELIVERY	
Pregnancy	<input type="checkbox"/> Normal <input type="checkbox"/> Difficult
Delivery	<input type="checkbox"/> Term <input type="checkbox"/> Pre-term <input type="checkbox"/> Post-term
Child's birthweight:	
Only child?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, circle birth order: 1 st 2 nd 3 rd 4 th 5 th 6 th 7 th

MEDICAL AND PSYCHIATRIC HISTORY		
PAST MEDICAL HISTORY		
Frequent nasal congestion	<input type="checkbox"/> Yes	Age of diagnosis:
Trouble breathing through his/her nose	<input type="checkbox"/> Yes	Age of diagnosis:
Sinus problems	<input type="checkbox"/> Yes	Age of diagnosis:
Chronic bronchitis or cough	<input type="checkbox"/> Yes	Age of diagnosis:
Allergies	<input type="checkbox"/> Yes	Age of diagnosis: Allergic to what:
Asthma	<input type="checkbox"/> Yes	Age of diagnosis:



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MEDICAL AND PSYCHIATRIC HISTORY
PAST MEDICAL HISTORY

Frequent colds or flus	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent ear infections	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent strep throat infections	<input type="checkbox"/> Yes	Age of diagnosis:
Difficulty swallowing	<input type="checkbox"/> Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux)	<input type="checkbox"/> Yes	Age of diagnosis:
Poor or delayed growth	<input type="checkbox"/> Yes	Age of diagnosis:
Excessive weight	<input type="checkbox"/> Yes	Age of diagnosis:
Hearing problems	<input type="checkbox"/> Yes	Age of diagnosis:
Speech problems	<input type="checkbox"/> Yes	Age of diagnosis:
Vision problems	<input type="checkbox"/> Yes	Age of diagnosis:
Seizures/Epilepsy	<input type="checkbox"/> Yes	Age of diagnosis:
Morning headaches	<input type="checkbox"/> Yes	Age of diagnosis:
Cerebral palsy	<input type="checkbox"/> Yes	Age of diagnosis:
Heart disease	<input type="checkbox"/> Yes	Age of diagnosis:
High blood pressure	<input type="checkbox"/> Yes	Age of diagnosis:
Sickle cell disease	<input type="checkbox"/> Yes	Age of diagnosis:
Genetic disease	<input type="checkbox"/> Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	<input type="checkbox"/> Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	<input type="checkbox"/> Yes	Age of diagnosis:
Cranofacial disorder (e.g., Pierre-Robin)	<input type="checkbox"/> Yes	Age of diagnosis:
Thyroid problems	<input type="checkbox"/> Yes	Age of diagnosis:
Eczema (itchy skin)	<input type="checkbox"/> Yes	Age of diagnosis:
Pain	<input type="checkbox"/> Yes	Age of diagnosis:



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PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY		
Autism	<input type="checkbox"/> Yes	Age of diagnosis:
Developmental delay	<input type="checkbox"/> Yes	Age of diagnosis:
Hyperactivity/ADHD	<input type="checkbox"/> Yes	Age of diagnosis:
Anxiety/Panic Attacks	<input type="checkbox"/> Yes	Age of diagnosis:
Obsessive Compulsive Disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Depression	<input type="checkbox"/> Yes	Age of diagnosis:
Suicide	<input type="checkbox"/> Yes	Age of diagnosis:
Learning disability	<input type="checkbox"/> Yes	Age of diagnosis:
Drug use/abuse	<input type="checkbox"/> Yes	Age of diagnosis:
Behavioral disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Psychiatric Admission	<input type="checkbox"/> Yes	Age of diagnosis:
Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.		
CURRENT MEDICAL HISTORY		
Please list any medications your child currently takes:		
Medicine	Dose	How often?
1.		
2.		
3.		
4.		
LONG-TERM MEDICAL PROBLEMS		
If your child has long-term medical problems, please list the three you think are most important.		
1.		
2.		
3.		


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SURGERIES/HOSPITALIZATIONS

Has your child ever had his/her tonsils removed? Yes No Age of surgery:

Has your child ever had his/her adenoids removed? Yes No Age of surgery:

Has your child ever had ear tubes? Yes No Age of surgery:

Please list any additional hospitalizations or surgeries:

HEALTH HABITS

Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea) No Yes Amount per day:

SCHOOL PERFORMANCE
CURRENT SCHOOL PERFORMANCE (if school-aged)

Your child's grade:

Has your child ever repeated a grade? No Yes

Is your child enrolled in any special education class? No Yes

How many school days has your child missed so far this year?

How many school days did your child miss last year?

How many school days was your child late so far this year?

How many school days was your child late last year?

Child's grades this year: Excellent Good Average Poor Failing

Child's grades last year: Excellent Good Average Poor Failing



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FAMILY'S INFORMATION

MOTHER		FATHER
Age:		Age:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried
Education:		Education:
Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time		Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time
Occupation:		Occupation:

PERSONS LIVING IN HOME

Name:	Relationship	Age

FAMILY SLEEP HISTORY

Does anyone in the family have a sleep disorder? Yes No

If yes, mark the disorder(s):

Insomnia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Snoring	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Sleep apnea	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Restless legs syndrome	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Periodic limb movement disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Sleepwalking/sleep terrors	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Sleep talking	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Narcolepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Other:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent



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REFERRAL	
Who asked that your child be seen by a sleep specialist?	
<input type="checkbox"/>	Pediatrician/Family physician
<input type="checkbox"/>	Child's parent or guardian
<input type="checkbox"/>	Surgical specialist (e.g., ENT)
<input type="checkbox"/>	Pediatric specialist (e.g., allergist, neurologist, pulmonologist)
<input type="checkbox"/>	Mental health specialist (e.g. psychiatrist, psychologist, social worker)
<input type="checkbox"/>	School teacher, nurse, counselor
<input type="checkbox"/>	Child himself/herself
<input type="checkbox"/>	Other:

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From: Mindell JA & Owens JA (2003). *A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems*. Philadelphia: Lippincott Williams & Wilkins.



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