Sleep Evaluation Questionnaire

ID #

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: ☐ Male ☐ Female	
Child's birthdate:			Child's age:	
Child's racial/ethnic background:	☐ White/Caucasian ☐ Native-American ☐ Other	☐ Black/African-American ☐ Hispanic-Latino	☐ Asian American ☐ Multi-racial	

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 *on weekdays* (add daytime and night-time sleep):	________ hours ________ minutes
The child's usual bedtime on *weekday nights*:	________ : ________
The child's usual *waketime* on *weekday mornings*:	________ : ________

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Weekend/Vacation Sleep Schedule	
Write in the amount of time child sleeps during a 24-hour period *during weekends and vacations* (add daytime and nighttime sleep):	________ hours ________ minutes
The child's usual bedtime on *weekend/vacation nights*:	________ : ________
The child's usual *waketime* on *weekend/vacation mornings*:	________ : ________

Nap Schedule
Number of *days each week* child takes a nap: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
If child naps, write in usual nap time(s):
Nap 1: ________ : ________ ☐ a.m. ☐ p.m. to ________ : ________ ☐ a.m. ☐ p.m.
Nap 2: ________ : ________ ☐ a.m. ☐ p.m. to ________ : ________ ☐ a.m. ☐ p.m.

General Sleep		
Does the child have a regular bedtime routine?	☐ yes	☐ no
Does the child have his/her own bedroom?	☐ yes	☐ no
Does the child have his/her own bed?	☐ yes	☐ no
Is a parent present when your child falls asleep?	☐ yes	☐ no

Child usually *falls asleep* in …	Child *sleeps most of the night* in …	Child usually *wakes in the morning* in …
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ own room in own bed (alone)
☐ parents' room in own bed	☐ parents' room in own bed	☐ parents' room in own bed
☐ parents' room in parent's bed	☐ parents' room in parent's bed	☐ parents' room in parent's bed
☐ sibling's room in own bed	☐ sibling's room in own bed	☐ sibling's room in own bed
☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed

Child is usually put to bed by: ☐ Mother ☐ Father ☐ Both Parents ☐ Self ☐ Others

Write in the *amount of time* the child spends in *his/her bedroom* before going to sleep: ________ minutes

Child resists going to bed?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child has difficulty falling asleep?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child awakens during the night?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
After nighttime awakening, child has difficulty falling back to sleep?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child is difficult to awaken in the morning?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child is a poor sleeper?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no

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Current Sleep Symptoms						
	(a) never (does not happen)	(b) not often (less than 1 night/day a week)	(c) sometimes (1 to 2 nights/days a week)	(d) often (3 to 5 nights/days a week)	(e) always (6 to 7 nights/days a week)	(f) do not know
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						
	(a) never (does not happen)	(b) not often (less than 1 days a week)	(c) sometimes (1 to 2 days a week)	(d) often (3 to 5 days a week)	(e) always (6 to 7 days a week)	(f) do not know
1. Trouble getting up in the morning	a	b	c	d	e	f
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	☐ Normal	☐ Difficult									
Delivery	☐ Term	☐ Pre-term	☐ Post-term								
Child's birthweight:											
Only child?	☐ Yes	☐ No	If no, circle birth order:	1st	2nd	3rd	4th	5th	6th	7th	

MEDICAL AND PSYCHIATRIC HISTORY			
PAST MEDICAL HISTORY			
Frequent nasal congestion	☐ Yes	Age of diagnosis:	
Trouble breathing through his/her nose	☐ Yes	Age of diagnosis:	
Sinus problems	☐ Yes	Age of diagnosis:	
Chronic bronchitis or cough	☐ Yes	Age of diagnosis:	
Allergies	☐ Yes	Age of diagnosis:	Allergies to what:
Asthma	☐ Yes	Age of diagnosis:	

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Frequent colds or flus	☐ Yes	Age of diagnosis:
Frequent ear infections	☐ Yes	Age of diagnosis:
Frequent strep throat infections	☐ Yes	Age of diagnosis:
Difficulty swallowing	☐ Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux?	☐ Yes	Age of diagnosis:
Poor or delayed growth	☐ Yes	Age of diagnosis:
Excessive weight	☐ Yes	Age of diagnosis:
Hearing problems	☐ Yes	Age of diagnosis:
Speech problems	☐ Yes	Age of diagnosis:
Vision problems	☐ Yes	Age of diagnosis:
Seizures/Epilepsy	☐ Yes	Age of diagnosis:
Morning headaches	☐ Yes	Age of diagnosis:
Cerebral palsy	☐ Yes	Age of diagnosis:
Heart disease	☐ Yes	Age of diagnosis:
High blood pressure	☐ Yes	Age of diagnosis:
Sickle cell disease	☐ Yes	Age of diagnosis:
Genetic disease	☐ Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	☐ Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	☐ Yes	Age of diagnosis:
Craniofacial disorder (e.g., Pierre-Robin)	☐ Yes	Age of diagnosis:
Thyroid problems	☐ Yes	Age of diagnosis:
Eczema (itchy skin)	☐ Yes	Age of diagnosis:
Pain	☐ Yes	Age of diagnosis:
PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY		
Autism	☐ Yes	Age of diagnosis:
Developmental delay	☐ Yes	Age of diagnosis:
Hyperactivity/ADHD	☐ Yes	Age of diagnosis:
Anxiety/Panic Attacks	☐ Yes	Age of diagnosis:
Obsessive Compulsive Disorder	☐ Yes	Age of diagnosis:
Depression	☐ Yes	Age of diagnosis:
Suicide	☐ Yes	Age of diagnosis:
Learning disability	☐ Yes	Age of diagnosis:
Drug use/abuse	☐ Yes	Age of diagnosis:
Behavioral disorder	☐ Yes	Age of diagnosis:
Psychiatric Admission	☐ Yes	Age of diagnosis:
Please list any additional psychological psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist		

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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.

SURGERIES/HOSPITALIZATIONS		
Has your child ever had his/her tonsils removed?	☐ Yes	Age of surgery:
Has your child ever had his/her adenoids removed?	☐ Yes	Age of surgery:
Has your child ever had ear tubes?	☐ Yes	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: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried	Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried
Education:	Education:
Work: ☐ Unemployed ☐ Part-time ☐ Full-time	Work: ☐ Unemployed ☐ Part-time ☐ 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	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent

REFERRAL

Who asked that your child be seen by a sleep specialist?

__________________ Pediatrician/Family physician

__________________ Child's parent or guardian

__________________ Surgical specialist (e.g., ENT)

__________________ Pediatric specialist (e.g., allergist, neurologist, pulmonologist

__________________ Mental health specialist (e.g., psychiatrist, psychologist, social worker)

__________________ School teacher, nurse, counselor

__________________ Child himself/herself

Other:

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