



Pediatric Sleep Questionnaire

NAME _____ DATE _____

AGE _____ DOB _____ SEX M F RACE _____ HANDEDNESS; R L

HEIGHT _____ inches WEIGHT _____ lbs

NAME OF PARENT / ADULT GUARDIAN _____

RELATIONSHIP; mother father grandparent other _____

REFERRING PHYSICIAN _____

Please answer the following questions as completely as possible. Space at the end of the questionnaire is for any further questions/comments/observations you think important.

If a particular **question does not apply** to your child please **write NA**.

If the question applies, but **you do not know** the answer, please **write DK**

1. What is the main reason for this sleep disorders evaluation? (That is, what is the primary complaint?) _____

2. Do you consider this problem to be mild / moderate / severe

3. How long has this been a problem? _____ months / years.

4. Has there been a sleep problem diagnosed in the past? yes no

If yes, a)Where? _____

b)What was the problem? _____

c)What treatment(s) and did/do they help? _____

SLEEP SCHEDULE / HYGIENE / ENVIRONMENT

1. What time does your child usually go to bed on weekdays? ____ am/pm
 2. What time is the bed room light turned off? ____ pm
 3. Who turns off the light? parent / child
 4. What time does your child usually get up on weekdays? ____ am/pm
 5. What time does your child usually go to bed on weekends? ____ am/pm
 6. What time does your child usually get up on weekends? ____ am/pm
 7. What time is the bedroom light turned off? ____ pm
 8. Who turns off the light? parent / child
 9. Do you keep this as a fairly regular sleep/wake schedule? yes no
 10. Does your child read/write in bed? yes no
play games in bed yes no
watch TV in bed? yes no
listen to music? yes no
eat in bed? yes no
have pet in room at night yes no
 11. Does your child need a special object / toy to go to bed? yes no
 12. Does your child need a bottle to go to sleep? yes
no
 13. As an infant did your child need any of the following devices to get to sleep?
swing snuggly car ride being held rocking other _____
 14. What type of bed is used now? crib single bed double bed other
 15. Is the bedroom quiet, dark and a comfortable temperature? yes no
 16. Does your child sleep alone? yes no
If no, with whom? _____
 17. On average, how long do you think it takes your child to fall asleep? _____ min / hrs
 18. Does your child cry when put to bed? yes no
if yes; do you let your child cry in bed in order to get to sleep? yes no
If yes; how long do you let them cry? 10 / 20 / 30 min / as long as it takes
 19. When unable to sleep, does your child get out of bed? yes no
if yes; how long after initially going to bed _____ min _____ hrs
if yes; what does your child do? _____

- how long are they up? _____ min _____ hrs

SLEEP BREATHING

1. Does your child snore? (circle one) never rarely occasionally frequently always
Please circle "loudness" rating below:

Your rating (none/minimal) **0 1 2 3 4 5 6 7 8 9 10** (very loud/disturbing)

2. With the snoring, do you see / hear any of the following:

- Choking yes no
- Episodes of stopping breathing yes no
- Struggling to breath? yes no
- Wheezing yes no
- Awakenings yes no

3. Does position affect the snoring? yes no

If yes, in which position is it the loudest? (circle one)
back right left stomach other

4. What is your child's preferred sleeping position? back left right stomach other

MOVEMENT

- 1. Are your child's bed covers extremely messy when they wake up? yes no
- 2. Does your child awaken themselves by kicking legs during the night? yes no
- 3. Sibling in same bed complains of leg kicking during the night? yes no
- 4. Does your child complain of aching legs / need to move legs.? yes no
If yes; is it worsened by inactivity such as lying or sitting? yes no
does movement, walking or stretching relieve it? yes no
is it worse in the evening or at bedtime? yes no
- 5. Does your child rock their body / head in bed before falling asleep? yes no

PARASOMNIAS

1. Does your child currently have nightmares? yes no
If yes, how frequently? _____ & when did they begin? _____
Did anything happen in their life that may have started the nightmares? yes no
Explain: _____

2. Does your child wake from sleep feeling very scared without an obvious reason? yes no

If yes, how frequently? _____
How long does it last? _____
Are these episodes associated with: sweating yes no
rapid heart beat yes no
Does your child scream and seem inconsolable? yes no

Does your child recall any dream or dream-fragments preceding an episode?

yes no

If yes, describe: _____

Are they confused during these episodes? yes no

Do they remember these episodes in the morning? yes no

Does your child flail arms / kick legs, or have other violent movements with these episodes? yes no

Do they ever wet the bed during these episodes? yes no

3. Does your child grind or clench their teeth at night? yes no

4. Does your child currently wet the bed? yes no

if yes, for how many years? _____

were they previously dry all night, then start wetting? yes no

5. Does your child currently sleepwalk? yes no in the past yes no

if yes, how often? _____

if yes, have they ever hurt themselves? yes no

please explain _____

6. Does your child seem to act out dreams in their sleep? yes no

FAMILY SLEEP HISTORY

1. Do other members of your immediate family snore? yes no

2. Do any members of your immediate family have sleep apnea? yes no

If yes, who: _____

3. Immediate family members with other sleep disorders? yes no

If yes, who & what disorder _____

4. Have there been crib deaths (sudden infant death syndrome) in your family? yes no

If yes, explain: _____

OPTIONAL

To better serve this community with information on sleep disorders and their treatments we would like to know how you heard about us: (Please Circle)

Doctor Phone book Newspaper Radio Television Friend or Family member

Other _____

Thank you for your cooperation filling out this questionnaire. Please be assured that this information is confidential.