Patient Name: _____

THE CENTER FOR SLEEP MEDICINE

PEDIATRIC SLEEP QUESTIONNAIRE

Please fill out the following questionnaire with information pertaining to your child.

IDENTIFYING INFORMATION

Patient First and Last Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: _____ Weight: _____ Lbs. Height: _____ Ft./in

Name of person completing questionnaire: _____

Relationship to patient: _____

PRESENTING PROBLEM

Please briefly describe your child's main sleep-related complaint: _____

_____

_____

_____

USUAL SLEEP HABITS

Please describe your child's *typical* sleep schedule:

1. On *weekdays*, my child goes to bed at: _____ (AM or PM?); wakes at: _____ (AM or PM?).
2. On *weekends*, my child goes to bed at: _____ (AM or PM?); wakes at: _____ (AM or PM?).
3. How long does it usually take your child to fall asleep? _____ (Indicate minutes or hours)

4a. How many times does your child wake up during the night? _____

4b. How long does it usually take your child to return to sleep? _____ (Indicate minutes or hours)

4c. My child is relatively ☐ EASY or ☐ DIFFICULT (*check one*) to wake up in the morning.

	Never	Little	Weekly	2-3 times/wk	Daily
5. How often does your child *usually* nap?	☐	☐	☐	☐	☐

6. Please describe any sleep comforts your child uses (e.g. blankets, plush toys or animals): _____

_____

SLEEP SYMPTOM DESCRIPTION

Please help us understand the nature of your child's sleep difficulties. Check any statement that applies:

1. ☐ My child snores
2. ☐ My child's bed covers are very messed up in the morning
3. ☐ My child tosses and turns at night and is a restless sleeper
4. ☐ My child kicks, jerks, or has limb movements (arms or legs) during sleep
5. ☐ My child has stopped breathing while asleep
6. ☐ My child refuses to go to bed, sleep in their own bed or go to sleep without assistance
7. ☐ My child wakes mid-sleep and cannot go back to sleep without assistance
8. ☐ My child has frequent nightmares
9. ☐ My child has frequent night terrors
10. ☐ My child sleep walks… How many times per week on average? _____
11. ☐ My child wets his/her bed… How many times per week on average? _____
12. ☐ My child is excessively sleepy during the daytime

EPWORTH SLEEPINESS SCALE FOR CHILDREN AND ADOLESCENTS (ESS-CHAD)

Over the past month, how likely have you been to fall asleep while doing the things that are described below (activites)? Even if you haven't done some of these things in the past month, try to imagine how they would have affected you. Use the following scale to choose one number that best describes what has been happening to you during each activity over the past month. Write that number in the box below.

Chance of Falling asleep:	0 = Never	1 = Slight chance	2 = Moderate chance	3 = High chance

Activity:	*Chance of falling asleep (0-3)*
1. Sitting and reading	
2. Sitting and watching TV or a video	
3. Sitting in a classroom at school during the morning	
4. Sitting and riding in a car or a bus for about half an hour	
5. Lying down to rest or nap in the afternoon	
6. Sitting and talking to someone	
7. Sitting quietly by yourself after lunch	
8. Sitting and eating a meal	

YOUR CHILD'S MEDICAL CONDITIONS

1. Please check all items that apply to your child:

☐ Easily distracted	☐ Hyperactive	☐ Anxiety or nervousness
☐ Overweight	☐ Underweight	☐ Bedwetting (if over 4 years of age)
☐ Asthma	☐ Sinus Problems	☐ Dizziness or passing out
☐ Headaches	☐ Seizures	☐ High blood pressure
☐ Chronic pain	☐ Depression	☐ Tonsillectomy/Adenoidectomy
☐ Heart problems	☐ Irregular heart beat	☐ Deviated septum/crooked or broken nose
☐ Developmental delay	☐ Learning disabilities	

2. Were the pregnancy and/or delivery with your child complicated? ☐ Yes ☐ No

   If yes, describe: _____

3. Was your child born on time? ☐ Yes ☐ No If "No," how premature was your child? _____

4. Please describe any other medical conditions or current physical complaints: _____

5. Please list all medications that your child takes, doses and time of administration:

6. Has your child undergone any surgeries? If yes, please explain below: ☐ Yes ☐ No

7. Does your child have any allergies? If yes, please describe these below: ☐ Yes ☐ No

OTHER INFORMATION

1. Please describe any additional information you feel may affect your child's sleep:

2. Please describe any special needs your child may have, in particular any that may affect treatment or care with us:

FAMILY HISTORY

1. Does anyone else in your family have sleep problems? ☐ Yes ☐ No

   If yes, describe their relationship to your child (e.g. mother, father, sister) and their condition: