Pediatric Sleep Questionnaire

Child's name: _____ Name of person answering the questions: _____

Relation to child: _____ Your phone number, days: _____

Your phone number, evenings: _____

Relative's name in case we cannot reach you:

Relative's number in case we cannot reach you:

Please answer the questions on the following pages regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general, not necessarily during the past few days since these may not have been typical if your child has not been well. If you are not sure how to answer any question, please feel free to ask your husband or wife, child, or physician for help. You should select the appropriate answer. When you see the word "usually" it means "more than half the time" or "on more than half the nights."

GENERAL INFORMATION ABOUT YOUR CHILD

Today's date: _____ dd / mm / yyyy

Where are you completing this questionnaire?:

Date of child's birth: _____ dd / mm / yyyy

Sex:

◯ Male ◯ Female ◯ Other

Current height (feet/inches): _____ Current weight (pounds): _____

Grade in school (if applicable): _____

Racial/Ethnic background of your child:

- ☐ American Indian
- ☐ Asian American
- ☐ African American
- ☐ Hispanic
- ☐ White/not Hispanic
- ☐ Other

A. NIGHTTIME AND SLEEP BEHAVIOR

While sleeping, does your child ever snore?

◯ Yes ◯ No ◯ Don't know

While sleeping, does your child snore more than half the time?

◯ Yes ◯ No ◯ Don't know

While sleeping, does your child always snore?

◯ Yes ◯ No ◯ Don't know

While sleeping, does your child snore loudly?

◯ Yes ◯ No ◯ Don't know

While sleeping, does your child have "heavy" or loud breathing?

◯ Yes ◯ No ◯ Don't know

While sleeping, does your child have trouble breathing, or struggle to breathe?

◯ Yes ◯ No ◯ Don't know

Have you ever seen your child stop breathing during the night?

◯ Yes ◯ No ◯ Don't know

If so, please describe what has happened:

Have you ever been concerned about your child's breathing during sleep?

◯ Yes ◯ No ◯ Don't know

Have you ever had to shake your sleeping child to get him or her to breathe, or wake up and breathe?

◯ Yes ◯ No ◯ Don't know

Have you ever seen your child wake up with a snorting sound?

◯ Yes ◯ No ◯ Don't know

Does your child have restless sleep?

◯ Yes ◯ No ◯ Don't know

Does your child describe restlessness of the legs when in bed?

◯ Yes ◯ No ◯ Don't know

Does your child have "growing pains" (unexplained leg pains)?

◯ Yes ◯ No ◯ Don't know

While your child sleeps, have you seen brief kicks of one leg or both legs?

◯ Yes ◯ No ◯ Don't know

While your child sleeps, have you seen repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)?

◯ Yes ◯ No ◯ Don't know

At night, does your child usually become sweaty, or do the pajamas usually become wet with perspiration?

◯ Yes ◯ No ◯ Don't know

At night, does your child usually get out of bed (for any reason)?

◯ Yes ◯ No ◯ Don't know

At night, does your child usually get out of bed to urinate?

◯ Yes ◯ No ◯ Don't know

If so, how many times each night, on average?:

Does your child usually sleep with the mouth open?

◯ Yes ◯ No ◯ Don't know

Is your child's nose usually congested or "stuffed" at night?

◯ Yes ◯ No ◯ Don't know

Do any allergies affect your child's ability to breathe through the nose?

◯ Yes ◯ No ◯ Don't know

Does your child tend to breathe through the mouth during the day?

◯ Yes ◯ No ◯ Don't know

Does your child have a dry mouth on waking up in the morning?

◯ Yes ◯ No ◯ Don't know

Does your child complain of an upset stomach at night?

◯ Yes ◯ No ◯ Don't know

Does your child get a burning feeling in the throat at night?

◯ Yes ◯ No ◯ Don't know

Does your child grind his or her teeth at night?

◯ Yes ◯ No ◯ Don't know

Does your child occasionally wet the bed?

◯ Yes ◯ No ◯ Don't know

Has your child ever walked during sleep ("sleep walking")?

◯ Yes ◯ No ◯ Don't know

Have you ever heard your child talk during sleep ("sleep talking")?

◯ Yes ◯ No ◯ Don't know

Does your child have nightmares once a week or more on average?

◯ Yes ◯ No ◯ Don't know

Has your child ever woken up screaming during the night?

◯ Yes ◯ No ◯ Don't know

Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep?

◯ Yes ◯ No ◯ Don't know

If so, please describe what has happened:

Does your child have difficulty falling asleep at night?

◯ Yes ◯ No ◯ Don't know

How long does it take your child to fall asleep at night? (a guess is O.K.):

At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly?

◯ Yes ◯ No ◯ Don't know

Does your child bang his or her head or rock his or her body when going to sleep?

◯ Yes ◯ No ◯ Don't know

Does your child wake up more than twice a night on average?

◯ Yes ◯ No ◯ Don't know

Does your child have trouble falling back asleep if he or she wakes up at night?

◯ Yes ◯ No ◯ Don't know

Does your child wake up early in the morning and have difficulty going back to sleep?

◯ Yes ◯ No ◯ Don't know

Does the time at which your child goes to bed change a lot from day to day?

◯ Yes ◯ No ◯ Don't know

Does the time at which your child gets up from bed change a lot from day to day?

◯ Yes ◯ No ◯ Don't know

What time does your child usually go to bed during the week?:

What time does your child usually go to bed on the weekend or vacation?:

What time does your child usually get out of bed on weekday mornings?:

What time does your child usually get out of bed on weekend or vacation mornings?:

B. DAYTIME BEHAVIOR AND OTHER POSSIBLE PROBLEMS

Does your child wake up feeling unrefreshed in the morning?

◯ Yes ◯ No ◯ Don't know

Does your child have a problem with sleepiness during the day?

◯ Yes ◯ No ◯ Don't know

Does your child complain that he or she feels sleepy during the day?

◯ Yes ◯ No ◯ Don't know

Has a teacher or other supervisor commented that your child appears sleepy during the day?

◯ Yes ◯ No ◯ Don't know

Does your child usually take a nap during the day?

◯ Yes ◯ No ◯ Don't know

Is it hard to wake your child up in the morning?

◯ Yes ◯ No ◯ Don't know

Does your child wake up with headaches in the morning?

◯ Yes ◯ No ◯ Don't know

Does your child get a headache at least once a month, on average?

◯ Yes ◯ No ◯ Don't know

Did your child stop growing at a normal rate at any time since birth?

◯ Yes ◯ No ◯ Don't know

If so, please describe what happened:

Does your child still have tonsils?

◯ Yes ◯ No ◯ Don't know

If not, when and why were they removed?

Has your child ever had a condition causing difficulty with breathing?

◯ Yes ◯ No ◯ Don't know

If so, please describe:

Has your child ever had surgery?

◯ Yes ◯ No ◯ Don't know

If so, did any difficulties with breathing occur before, during, or after surgery?

Has your child ever become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?

◯ Yes ◯ No ◯ Don't know

Has your child everfelt unable to move for a short period, in bed, though awake and able to look around?

◯ Yes ◯ No ◯ Don't know

Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?

◯ Yes ◯ No ◯ Don't know

Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?

◯ Yes ◯ No ◯ Don't know

Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)?

◯ Yes ◯ No ◯ Don't know

If so, how many cups or cans per day?: _____

Does your child use any recreational drugs?

◯ Yes ◯ No ◯ Don't know

If so, which ones and how often?

Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products?

◯ Yes ◯ No ◯ Don't know

If so, which ones and how often?

Is your child overweight?

◯ Yes ◯ No ◯ Don't know

If so, at what age did this first develop?:

Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?

◯ Yes ◯ No ◯ Don't know

Has your child ever taken Ritalin (methylphenidate) for behavioral problems?

◯ Yes ◯ No ◯ Don't know

Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?

◯ Yes ◯ No ◯ Don't know

C. OTHER INFORMATION

1. If you are currently at a clinic with your child to see a physician, what is the problem that brought you?

2. If your child has long-term medical problems, please list the three you think are most significant.

3. Please list any medications your child currently takes:

4. Please list any medication your child has taken in the past if the purpose of the medication was to improve his or her behavior, attention, or sleep:

5. Please list any sleep disorders diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

6. Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

7. Please list any sleep or behavior disorders diagnosed or suspected in your child's brothers, sisters, or parents:

D. ADDITIONAL COMMENTS

Please use the space below to print any additional comments you feel are important. Please also use this space to describe details regarding any of the above questions.

Please indicate, by selecting the appropriate answer, how much each statement applies to this child:

This child often does not seem to listen when spoken to directly.

0 - Does not apply 1 - Applies just a little 2 - Applies quite a little bit 3 - Definitely applies most of the time

This child often has difficulty organizing tasks and activities.

0 - Does not apply 1 - Applies just a little 2 - Applies quite a little bit 3 - Definitely applies most of the time

This child often is easily distracted by extraneous stimuli.

0 - Does not apply 1 - Applies just a little 2 - Applies quite a little bit 3 - Definitely applies most of the time

This child often fidgets with hands or feet or squirms in seat.

0 - Does not apply 1 - Applies just a little 2 - Applies quite a little bit 3 - Definitely applies most of the time

This child often is "on the go" or often acts as if "driven by a motor".

0 - Does not apply 1 - Applies just a little 2 - Applies quite a little bit 3 - Definitely applies most of the time

This child often interrupts or intrudes on others (e.g., butts into conversations or games).

0 - Does not apply 1 - Applies just a little 2 - Applies quite a little bit 3 - Definitely applies most of the time