

Place Patient Label Here

Pediatric Sleep Questionnaire

Patient Name: _____ Male Female DOB: _____ Age: _____
Parent/Guardian: _____ Email: _____
Address: _____
City/State/Zip: _____
Primary Care Physician: _____ Referring Physician: _____
Neck size _____ (cm/inches) Height (inches): _____ Weight: _____ School Grade: _____

Describe your child's main problem(s) in your own words, including when and how this began and what treatment(s) your child has received for this in the past:

How long has this problem bothered your child?

<input type="checkbox"/> The last month
<input type="checkbox"/> The last 3 months
<input type="checkbox"/> Several months
<input type="checkbox"/> 1 to 2 years
<input type="checkbox"/> Longer than 2 years

How often does this problem occur?

<input type="checkbox"/> Every night
<input type="checkbox"/> Almost every night
<input type="checkbox"/> For periods of at least one week
<input type="checkbox"/> Irregularly
<input type="checkbox"/> Other

Is your child being treated for any medical conditions? If so please list below:

<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Reflux
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other:
<input type="checkbox"/> Lung problems/asthma	<input type="checkbox"/>
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/>
<input type="checkbox"/> Seizures	<input type="checkbox"/>
<input type="checkbox"/> Stomach or colon problems	<input type="checkbox"/>

Does your child take any type of medication on a regular basis? Yes No If YES, please list below

Medication	Amount	How often	Reason

Has his/her tonsils been removed? Yes No If so when? _____

Has his/her adenoids been removed? Yes No If so when? _____

Has your child had a weight gain or loss in the last 6 months? Yes No If so how much gained _____ or how much lost _____?



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Using the scale below, estimate the severity of your child's problem(s):

<input type="checkbox"/> Mildly upsetting
<input type="checkbox"/> Moderately upsetting
<input type="checkbox"/> Very severe
<input type="checkbox"/> Extremely severe
<input type="checkbox"/> Totally incapacitating

How would you describe the sleep problem? (Check all that apply)

<input type="checkbox"/> Difficulty falling asleep
<input type="checkbox"/> Wake up during the night
<input type="checkbox"/> Wake up early in the morning
<input type="checkbox"/> Excessive daytime sleepiness
<input type="checkbox"/> Difficulty awakening

Do any other members of your family have sleep problems? Yes No if yes, explain:

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Using the following scale, rate how often the following occurs:

1-Never (No) 2-Rarely 3-Sometimes 4-Frequently 5-Constantly (Yes)

1 2 3 4 5

	1	2	3	4	5
Awaken from sleep short of breath					
Awaken with heartburn, belching or coughing					
Snore					
Snore loudly enough others complain					
Have trouble sleeping when he/she has a cold					
Suddenly wakes up gasping for breath during the night					
Have breathing problems at night					
Sweat at night					
Experience bedwetting while sleeping					
Fall asleep during the day					
Fall asleep while playing					
Fall asleep when laughing or crying					
Experience weakness when sad or happy					
Have trouble at school because of sleepiness					
Feel unable to move (paralyzed) when waking or falling asleep					
Experience dreamlike scenes upon waking up or falling asleep					
Feel afraid of going to sleep					
Have nightmares					
Remember his/her dreams					
Feel sad and depressed					
Have anxiety (worry about things)					
Notice parts of his/her body jerk					
Kick during the night					
Have crawling and aching feeling in his/her legs					
Have any type of leg pain during the night					
Have morning jaw pain					
Grind teeth during sleep					
Bothered by pain during the day					
Awakened by pain during the night					
Wake up feeling stiff in the mornings					
Wake up with sore or achy muscles					
Wake up with pain in neck, spine or joints					



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Is your child's present school situation satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, explain):	
How many hours of sleep does your child get per night? _____ hours	
What is your child's typical bedtime? _____ Weekdays _____ Weekends	
How long does it take for your child to fall asleep? _____ minutes/hours	
Typical number of awakenings per night? _____	
If he/she awakens, how long does he/she average staying awake? _____ minutes/hours	
What does your child usually do when he/she awakens during the night?	
When do these awakenings typically happen? <input type="checkbox"/> Soon after falling asleep <input type="checkbox"/> Middle of the night <input type="checkbox"/> Early morning	
Typical wake up time each morning? _____ a.m./p.m. Weekdays _____ a.m./p.m. Weekends	
On average, how long does your child stay in bed after waking up in the morning? _____ minutes/hours	
Mark all that apply to your child: <input type="checkbox"/> Usually sleeps with someone else in his/her bed. <input type="checkbox"/> Usually sleeps with someone else in his/her room.	
Mark all that often disturb your child's sleep: <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Light <input type="checkbox"/> Noise <input type="checkbox"/> Bed partner <input type="checkbox"/> Not being in his/her usual bed <input type="checkbox"/> Other: _____	
Are your child's sleep habits on the weekends different from the rest of the week? <input type="checkbox"/> Yes (if yes describe) <input type="checkbox"/> No	
With whom is your child now living? (Siblings, parents, etc., please list ages)	
Does your child drink coffee, tea or soft drinks within two hours of going to bed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List below in the appropriate space your child's consumption per day of the following items: (list names where applicable)	
	Amount Consumed:
Coffee	_____ oz.
Soft Drinks	_____ oz.
Chocolate	_____ oz.
Nicotine	_____
Alcohol	_____ oz.
Over the counter drugs	_____
Other drugs not listed above	_____
Does your child take naps during the afternoon or evening? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How does your child feel after an average night of sleep? <input type="checkbox"/> Usually drowsy and/or tired for up to 1 hour. <input type="checkbox"/> Usually drowsy and/or tired for up to 2 hours. <input type="checkbox"/> Usually drowsy and/or tired for 3 hours or longer. <input type="checkbox"/> Good most of the time. <input type="checkbox"/> Consistently good.	
Does your child feel better during the <input type="checkbox"/> morning <input type="checkbox"/> afternoon, or <input type="checkbox"/> evening?	

