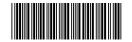


# SLEEP EVALUATION QUESTIONNAIRE

### Directions

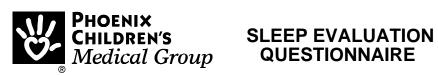
Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

	CHILD'S I	NFORMATION	
Child's name:		Child's gender Male Femal	e
Child's birthdate:		Child's age:	
Child s racial/ethnic background:	White/Caucasian	Black/African-American	🗌 Asian-American
	□ Native–American	🗌 Hispanic-Latino	Multi-racial
	□ Other		
What are your major concern	s about your child s slee	ep?	
What things have you tried to	help your child s proble	em?	



Page 1 of 8





	SLEEP HISTORY	
Weekday Sleep Schedule		
Write in the amount of time child sleeps du period <u>on weekdays</u> (add daytime and nig		minutes
The child s usual <u>bedtime</u> on <u>weekday nig</u>	<u>nts</u> :;;	
The child s usual <u>waketime</u> on <u>weekday m</u>	ornings::	
Weekend/Vacation Sleep Schedule		
Write in the amount of time child sleeps du <u>during weekends and vacations</u> (add dayti		minutes
The child s usual <u>bedtime</u> on <u>weekend/vac</u>	ation nights:	
The child s usual waketime on weekend/va	acation mornings::	
Nap Schedule		
Number of <u>days each week</u> child takes a n	ap: 0 0 1 0 2 0	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 rout	ine?	🗌 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 as	sleep?	🗌 yes 🔲 no
Child usually <u>falls asleep</u> in	Child sleeps most of the night in	Child usually wakes in the morning in
☐ own room in own bed (alone)	$\Box$ own room in own bed (alone)	$\Box$ own room in own bed (alone)
parents room in own bed	parents room in own bed	$\Box$ parents room in own bed
☐ parents room in parents bed	parents room in parents bed	$\Box$ parents room in parents 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:	er $\Box$ Father $\Box$ Both Parents $\Box$ Se	lf 🗌 Others
Write in the amount of time the child spend	Is in <u>his/her bedroom</u> before going to sleep:_	minutes
Child resists going to bed?	☐ yes ☐ no <b>If yes</b> , do you think t	this is a problem? □ yes □ no
Child has difficulty falling asleep?	☐ yes ☐ no <b>If yes</b> , do you think t	this is a problem? □ yes □ no
Child awakens during the night?	☐ yes ☐ no <b>If yes</b> , do you think t	this is a problem?
After nighttime awakening, child has difficulty falling back to sleep?	☐ yes ☐ no <b>If yes</b> , do you think t	this is a problem?
Child is difficult to awaken in the morning?	☐ yes ☐ no <b>If yes</b> , do you think t	this is a problem? □ yes □ no
Child is difficult to awaken in the morning?	☐ yes ☐ no <b>If yes</b> , do you think t	this is a problem?

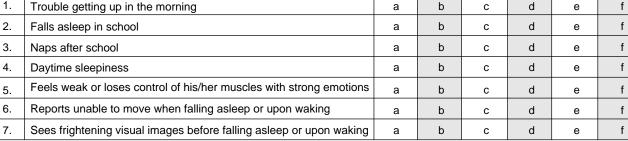




### SLEEP EVALUATION QUESTIONNAIRE

**Division of Neurology** 

Curre	ent Sleep Symptoms						
						(f) do no	t know
		(e	) alway	s (6 to 7	7 days a	week)	
		d) often	-	-	veek)		
	(c) sometimes	•		veek)			
	(b) not often (less than	-	week)				
4	(a) never (does not hap	<u> </u>	b		4		4
1.	Difficulty breathing when asleep	a	-	С	d	e	f
2.	Stops breathing during sleep	а	b	С	d	e	f
3.	Snores	а	b	С	d	е	f
4.	Restless sleep	а	b	С	d	е	f
5.	Sweating when sleeping	а	b	с	d	е	f
6.	Daytime sleepiness	а	b	с	d	е	f
7.	Poor appetite	а	b	с	d	е	f
8.	Nightmares	а	b	с	d	е	f
9.	Sleepwalking	а	b	с	d	е	f
10.	Sleeptalking	а	b	с	d	е	f
11.	Screaming in his/her sleep	а	b	с	d	е	f
12.	Kicks legs in sleep	а	b	с	d	е	f
13.	Wakes up at night	а	b	с	d	е	f
14.	Gets out of bed at night	а	b	с	d	е	f
15.	Trouble staying in his/her bed	а	b	с	d	е	f
16.	Resists going to bed at bedtime	а	b	с	d	е	f
17.	Grinds his/her teeth	а	b	с	d	е	f
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	а	b	с	d	е	f
19.	Wets bed	а	b	с	d	е	f
Curre	ent Daytime Symptoms	1					
						(f) do no	t know
		-		s (6 to 7	-		
		d) often			veek)		
	(c) sometimes	•	•	veek)			
	(b) not often (less than	-	week)				
	(a) never (does not hap	-					
1.	Trouble getting up in the morning	а	b	С	d	е	f
2.	Falls asleep in school	a	b	l c	d	l e	l f







Division of Neurology

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:	Allergic to what:			
Asthma	Yes	Age of diagnosis:				
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 (gastroesophagealreflux)	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:				
Chromosomeproblem (e.g., Down?s)	Yes	Age of diagnosis:				
Skeleton problem (e.g., dwarfism)	Yes	Age of diagnosis:				
Cranofacial 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:				



DOS:



## SLEEP EVALUATION QUESTIONNAIRE

**Division of Neurology** 

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.

### CURRENT MEDICAL HISTORY

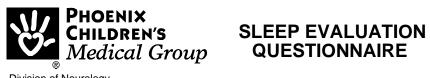
Please list any medications your child currently takes:							
Medicine	Dose	How often?					
1							
4							
LONG-TERM MEDICAL PROBLEMS							

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

1		
2		
3		



DOS:



Division of Neurology

SURGERIES/HOSPITALIZATIONS				
Has your child ever had his/her tonsils removed?	🗆 No	□ Yes	Age of surgery:	
Has your child ever had his/her adenoids removed?	🗆 No	🗌 Yes	Age of surgery:	
Has your child ever had ear tubes?	🗌 No	□ Yes	Age of surgery:	
Please list any additional hospitalizations or surgeries:				

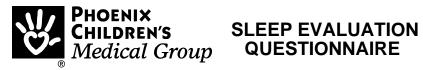
HEALTH HABITS			
Does your child drink caffeinated beverages? (e.g., Coke,Pepsi, Mountain Dew, iced tea)	🗆 No	□ Yes	Amount per day:

PREGNANCY/ DELIVERY		
Pregnancy	Normal	Difficult
Delivery	Term	Pre-term Post-term
Child s birth weight:		
Only child?	□ Yes	$\Box$ No If no, circle birth order: 1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> 4 <sup>th</sup> 5 <sup>th</sup> 6 <sup>th</sup> 7 <sup>th</sup>

## SCHOOL PERFORMANCE

CURRENT SCHOOL PERFORMANCE (if school-aged)					
Your child s grade:					
Has your child ever repeated a grad	le?	🗌 No	□ Yes		
Is your child enrolled in any special	education class?	🗆 No	□ Yes		
How many school days has your ch	ild missed so far tl	his year?			
How many school days did your chi	Id miss last year?				
How many school days was your ch	nild 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

DOS:



FAMILY S INFORMATION					
MOTHER			FATHER		
Age:			Age:		
Marital Status	Separated		Marital Status  Single Divorced  Separated		
Married Widowed	Remarried		Married      Widowed      Remarried		
Education:			Education:		
Work: Unemployed Part-time	□Full-time		Work: Unemployed Part-time Full-time		
Occupation:			Occupation:		
PERSONS IN HOME					
Name:	Relationship		Age		

FAMILY SLEEP HISTORY					
Does anyone in the family have a sleep disorder?		□ <sub>Yes</sub> [	□ 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 leg sydrome	□ Mother	□ Father	Brother/sister	Grandparent	
Periodic limb movement disorder	Mother	□ Father	Brother/sister	Grandparent	
Sleepwalking/sleep terror	□ Mother	□ Father	Brother/sister	Grandparent	
Sleeptalking	□ 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:		

Signature of Patient/Legally Authorized Representative	Date & Time
Printed Name of Patient/Legally Authorized Representative	Relationship to Patient
Practitioner Signature	Date & Time
Printed Name	

