



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 INFORMATION	
Child's name:	Child's gender Male Female
Child's birthdate:	Child's age:
Child's racial/ethnic background:	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian-American <input type="checkbox"/> Native-American <input type="checkbox"/> Hispanic-Latino <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other
What are your major concerns about your child's sleep?	
What things have you tried to help your child's problem?	





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Division of Neurology

Current Sleep Symptoms							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 day a week)				
		(a) never (does not happen)					
1.	Difficulty breathing when asleep	a	b	c	d	e	f
2.	Stops breathing during sleep	a	b	c	d	e	f
3.	Snores	a	b	c	d	e	f
4.	Restless sleep	a	b	c	d	e	f
5.	Sweating when sleeping	a	b	c	d	e	f
6.	Daytime sleepiness	a	b	c	d	e	f
7.	Poor appetite	a	b	c	d	e	f
8.	Nightmares	a	b	c	d	e	f
9.	Sleepwalking	a	b	c	d	e	f
10.	Sleeptalking	a	b	c	d	e	f
11.	Screaming in his/her sleep	a	b	c	d	e	f
12.	Kicks legs in sleep	a	b	c	d	e	f
13.	Wakes up at night	a	b	c	d	e	f
14.	Gets out of bed at night	a	b	c	d	e	f
15.	Trouble staying in his/her bed	a	b	c	d	e	f
16.	Resists going to bed at bedtime	a	b	c	d	e	f
17.	Grinds his/her teeth	a	b	c	d	e	f
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19.	Wets bed	a	b	c	d	e	f
Current Daytime Symptoms							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 day a week)				
		(a) never (does not happen)					
1.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f





SLEEP EVALUATION QUESTIONNAIRE

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 (gastroesophageal reflux)	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:	
Chromosome problem (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:	





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. _____		
2. _____		
3. _____		
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. _____





SURGERIES/HOSPITALIZATIONS		
Has your child ever had his/her tonsils removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Age of surgery:
Has your child ever had his/her adenoids removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Age of surgery:
Has your child ever had ear tubes?	<input type="checkbox"/> No <input type="checkbox"/> 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)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount per day:

PREGNANCY/ DELIVERY		
Pregnancy	<input type="checkbox"/> Normal <input type="checkbox"/> Difficult	
Delivery	<input type="checkbox"/> Term <input type="checkbox"/> Pre-term <input type="checkbox"/> Post-term	
Child's birth weight:		
Only child?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, circle birth order: 1 st 2 nd 3 rd 4 th 5 th 6 th 7 th

SCHOOL PERFORMANCE		
CURRENT SCHOOL PERFORMANCE (if school-aged)		
Your child's grade:		
Has your child ever repeated a grade?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Is your child enrolled in any special education class?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
How many school days has your child missed so far this year?		
How many school days did your child miss last year?		
How many school days was your child late so far this year?		
How many school days was your child late last year?		
Child's grades this year:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/> Failing	
Child's grades last year:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/> Failing	





FAMILY S INFORMATION

MOTHER	FATHER
Age:	Age:
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried
Education:	Education:
Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time
Occupation:	Occupation:

PERSONS IN HOME

Name:	Relationship	Age

FAMILY SLEEP HISTORY

Does anyone in the family have a sleep disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, mark the disorder(s):				
Insomnia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Snoring	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Sleep apnea	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Restless leg syndrome	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Periodic limb movement disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Sleepwalking/sleep terror	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Sleeptalking	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Narcolepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grandparent
Other:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> 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

