Child Sleep Questionnaire *(3-12 years of age)*

Patient Information

LAST, FIRST, MIDDLE _____

DATE OF BIRTH _____ GENDER: ☐ MALE ☐ FEMALE

MOTHER'S NAME _____ FATHER'S NAME _____

Please circle or fill in

1. Describe what the sleep problem is: _____

   _____

2. What is your child's normal bedtime? _____ Wake up time: _____

3. What positions does the patient sleep in? (check all that apply) ☐ Back ☐ Side ☐ Stomach

4. Has the child ever had a sleep study? ☐ YES ☐ NO
   If YES, what was the diagnosis and treatment? _____

5. Please list current medications: _____

6. Does your child use medication for their sleep problem? ☐ YES ☐ NO
   If YES, please describe: _____

7. Is there a family history of any of the following disorders? (check all that apply)
   ☐ Narcolepsy ☐ Sudden Infant Death Syndrome (SIDS) ☐ Sleep Terrors
   ☐ Excessive Daytime Sleepiness ☐ Bed Wetting ☐ Head Banging

8. Is your child sleepy during waking hours? ☐ YES ☐ NO

9. Is your child hyperactive during waking hours? ☐ YES ☐ NO

10. What is the child's best time of day (when most alert)? _____

11. What is the worst time of day (when most sleepy)? _____

12. How many times a day does your child take naps? _____

13. Have you ever noted your child to have an over-powering, irresistible attack of sleep? ☐ YES ☐ NO
    If YES, describe how frequently this occurs and in what situations. _____

14. Does your child ever lose muscle strength when excited, startled, angry, or laughing?
    (for example weakness in knees, sagging facial muscles or total collapse) ☐ YES ☐ NO

15. Does your child ever see or hear things that are not real as he/she goes to sleep or wakes up? ☐ YES ☐ NO

16. Do any family members have symptoms listed in the last three questions? ☐ YES ☐ NO

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Check any of the following that have been observed in the child

- ☐ Refuses to go to bed
- ☐ Awakens at night for a drink or feeding
- ☐ Repeatedly gets out of bed
- ☐ Awakens during night and gets into parent's bed
- ☐ Refuses to sleep alone
- ☐ Bangs head or rocks until asleep
- ☐ Cries until asleep
- ☐ Reluctant to go to sleep due to fears
- ☐ Has frightening dreams
- ☐ Insists on sleep with parents, etc.
- ☐ Can relate details of frightening dreams
- ☐ Talks in sleep
- ☐ Walks in sleep
- ☐ Grinds teeth in sleep
- ☐ Moves excessively during sleep
- ☐ Has jerking of arms or legs during sleep
- ☐ Snores or has labored breathing during sleep
- ☐ Stops breathing during sleep
- ☐ Wets bed during sleep
- ☐ Arouses screaming in terror
- ☐ Gets out of bed and urinates on floor
- ☐ Has seizures or convulsions during sleep
- ☐ Awakens at night for bathroom or diaper change
- ☐ Sleeps better away from home
- ☐ Requires nightlight
- ☐ Other: _____

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Comments

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