Sleep, Breathing and Habit Questionnaire

Patient Name:_____ Age:_____ Date:_____

Please indicate symptoms of your child by using this scale to measure the severity of the following symptoms

0= No Occurrence 1= Occurs Rarely 2= Occurs 2-4 times per week 3= Occurs 5-7 times per week

_____ Snoring
_____ Interrupted snoring where breathing stops
_____ Labored, difficult or loud breathing at night
_____ Gasping for air while sleeping
_____ Mouth breathing while sleeping
_____ Mouth breathing during the day
_____ Restless sleep
_____ Grinding teeth
_____ Talking in sleep
_____ Excessive sweating while sleeping
_____ Waking up at night
_____ Wetting the bed (currently)
_____ History of bedwetting
_____ Feeling sleeping and/or irritable during the day

_____ Headaches
_____ Frequent throat infections
_____ Seasonal allergies
_____ Ear infections or history of ear infections
_____ Short attention span
_____ Trouble focusing
_____ Difficulty listening/often interrupts
_____ Hyperactivity
_____ ADD/ADHD
_____ Sensory issues
_____ Struggles in math in school
_____ Struggles with reading in school
_____ Speech issues *
_____ Avoidance behavior towards food or certain types of food

Speech Questionnaire- please fill this area out if you marked speech issues above.
Please check all that apply to your child

___ Is it difficult to understand your child's speech
___ Difficult to understand over the phone
___ Nasal speech
___ Hoarseness
___ Others have difficulty understanding speech

___ Gets frustrated when people can't understand speech
___ Speech sounds abnormal
___ Sometimes omits consonants
___ Uses M, N, NG instead of P, V, S, Z sounds
___ Liquids and/or solids get into nasal area when eating or drinking