National Sleep Solutions Inc.
Sleep specialist

THE EPWORTH SLEEPINESS SCALE

Name:_____
Your age (years):_____
Your sex (Please circle): M F
Date:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = Would *never* doze
1 = *Slight* chance of dozing
2 = *Moderate* chance of dozing
3 = *High* chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (i.e. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when the circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE
SLEEP
ACCREDITED MEMBER LAB

PEDIATRIC SLEEP QUESTIONNAIRE

Child's Name: _____, _____, _____
Last First MI

Name of Person Answering Questions: _____

Relation to child: _____

Your phone number, Days: _____ and evenings: _____
Area Code Number Area Code Number

Relative's name and number in case we cannot reach you:_____
Area Code Number

Instructions:

Please answer the questions on the following pages regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child's acts in general, not necessarily during the past few days since these may not have been typical, if your child has not been well. If you are not sure how to answer any questions, please feel to ask your husband or wife, child, or physician for help. You should circle the correct response or print your answer neatly in the space provided. A "y" means "yes", "N" means "no" and "DK" means "don't know". When you see the word "usually it means "more than half the time" or "on more that half the nights".

GENERAL INFORMATION ABOUT YOUR CHILD

Today's Date: _____
Month Day Year

Where are you completing this questionnaire? _____

Date of Child's Birth: _____
Month Day Year

Sex: Male or Female

Current Height (feet/inches):_____

Grade in School (if applicable):_____

Current Weight (pounds):_____

Racial/Ethnic Background of your Child (Please circle):

1. American - Indian
2. Asian - American
3. African - American
4. Hispanic
5. White/not Hispanic
6. Other or Unknown

A. Nighttime and sleep behavior **WHILE SLEEPING DOES YOUR CHILD…**		Office Use only
… ever snore?	Y N DK	
… snore more that half the time?	Y N DK	
… always snore?	Y N DK	
… snore loudly?	Y N DK	
… have "heavy" or loud breathing?	Y N DK	
… have trouble breathing, or struggle to breath?	Y N DK	
HAVE YOUR EVER…		
… seen your child stop breathing during the night? If so, please describe what happened:	Y N DK	
… been concerned about your child breathing during sleep?	Y N DK	
… had to shake your sleeping child to get him or her to breathe, or wake up and breathe?	Y N DK	
… seen your child wake up with a snorting sound?	Y N DK	
DOES YOUR CHILD…		
… have restless sleep?	Y N DK	
… describe restlessness of legs when in bed?	Y N DK	
… have "growing pains" (unexplained leg pains)?	Y N DK	

… have "growing pains" the are worst in bed?	Y	N	DK	
WHILE YOUR CHILD SLEEPS HAVE YOU SEEN…				
brief kicks on one legs or both legs?	Y	N	DK	
repeated kicks or jerks of the legs at regular intervals (.e., about every 20 to 40 seconds)?	Y	N	DK	
AT NIGHT DOES YOUR CHILD…				
… become sweaty, or do the pajamas usually become wet with perspiration?	Y	N	DK	
…get out of bed (for any reason)?	Y	N	DK	
… get out of bed to urinate? If so, how many times each night, on average?	Y	N	DK	
Does your child usually sleep with the mouth open?	Y	N	DK	
Is your child's nose usually congested or "stuffed" at night?	Y	N	DK	
Do any allergies affect your child's ability to breathe through the nose?	Y	N	DK	
DOES YOUR CHILD…				
…tend to breathe through the mouth during the day?	Y	N	DK	
…have a dry mouth on waking up in the morning?	Y	N	DK	
… complain of an upset stomach at night?	Y	N	DK	
… get burning feeling in the throat at night?	Y	N	DK	
… grind his or her teeth at night?	Y	N	DK	

… occasionally wet the bed?	Y N DK	
Has your child ever walked during sleep ("sleep walking")?	Y N DK	
Does your child have nightmares one a week or more on average?	Y N DK	
Has your child ever woken up screaming during the night?	Y N DK	
Has your child ever been moving or behaving, as night, in a way that made you think your child was neither completely awake nor asleep? If so, Please describe what has happened:	Y N DK	
Does your child have difficulty falling asleep at night?	Y N DK	
How long does it take your child to fall asleep at night? (a guess is Ok)	Y N DK	
At bedtime does your child usually have difficult "routines" or "rituals", argue a lot or otherwise behave badly?	Y N DK	
DOES YOUR CHILD…		
… bang his or her head or rock his or her body when going to sleep?	Y N DK	
… wake up more that twice a night on average	Y N DK	
… have trouble falling back asleep if he or she wakes up at night?	Y N DK	
…wake up early in the morning and have difficulty going back to sleep?	Y N DK	

Does the time at which your child goes to bed change a lot from day to day?	Y N DK	
Does the time at which your child gets upon from bed change a lot from day to day?	Y N DK	
WHAT TIME DOES YOUR CHILD USUALLY…		
…got to bed during the week?	Y N DK	
… go to bed on the weekend or vacation?	Y N DK	
… get out of bed on weekday mornings?	Y N DK	
…get out of bed on weekend or vacation mornings?	Y N DK	

B. Daytime behaviors and other possible problems: **DOES YOUR CHILD…**		Office Use Only
…Wake up feeling unrefreshed in the morning?	Y N DK	
… Have a problem with sleepiness during the day?	Y N DK	
…Complain that he or she feels sleepy during the day?	Y N DK	
Has a teacher or other supervisor commented that your child appears sleepy during the day?	Y N DK	
Does your child usually take a nap during the day?	Y N DK	
Is it hard to wake your child up in the mornings?	Y N DK	

Does your child wake up with headaches in the morning?	Y N DK	
Does your child get a headache at least one a month, on average?	Y N DK	
Did your child stop growing at a normal rate at any time since birth? If so, describe what happened	Y N DK	
HAS YOUR CHILD EVER…		
…had a condition causing difficulty with breathing? If so, please describe	Y N DK	
…had surgery? If so, did any difficulties with breathing occur before, during or after surgery?	Y N DK	
… become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?	Y N DK	
… Felt unable to move for a short period, in bed, though awake and able to look around?	Y N DK	
Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?	Y N DK	

Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?	Y N DK	
Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)? If so, how many cups or cans per day?	Y N DK	
Does your child use any recreational drugs? If so, which ones and how often?	Y N DK	
Is your child overweight? If so, at what age did this first develop?	Y N DK	
Has a doctor ever told you that your child has a high - arched palate (roof of the mouth)?	Y N DK	
Has your child ever taken a medication call Ritalin (Methylphenidate)?	Y N DK	
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?	Y N DK	

C. OTHER INFORMATION

1. If you are currently at a clinic with your child to see a physician, what is the problem that brought you?

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

3. Please list any medications your child currently takes:

Medicine	Size (mg) or amount per dose	Taken when?

4. Please list any medication your child has taken in the past if the purpose of the medication was to improve his or her behavior, attention, or sleep:

Medicine	Size (mg) or amount per dose	Taken how often?	Dates Taken

5. Please list any sleep disorders diagnosed or suspected by a physician in your child. For each problem, Please list the date it started and whether or not it is still present.

6. Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

7. Please list any sleep or behavior disorders diagnosed or suspected in your child's brothers, sisters or parents:

Relative	Condition
_____	_____
_____	_____
_____	_____

D. Additional Comments:

Please use the space below to write any additional comments you feels are important, please use this space to describe details regarding any of the above questions (and indicate the number of the questions to which you are referring). Be careful to print neatly.