National Sleep Solutions Inc.
Sleep Specialist

Name:_____

PEDIATRIC SLEEP QUESTIONNAIRE

Please fill out the following questionnaire with information pertaining to your child.

IDENTIFYING INFORMATION

Patient First and Last Name: _____. Date: _____

Age: _____. Date of Birth: _____ Gender:_____ Weight: _____ Height:_____

Name of person completing questionnaire:_____

Relationship to patient: _____

PRESENTING PROBLEM

Please briefly describe your child's main sleep-related complaint:_____

_____

USUAL SLEEP HABITS

Please describe your child's *typical* sleep schedule:

1. On *weekdays*, my child goes to bed at: _____ (AM or PM?); wakes at: _____ (AM or PM?)

2. On *weekends*, my child goes to bed at: _____ (AM or PM?); wakes at: _____ (AM or PM?)

3. How long does it usually take your child to fall asleep? _____ (indicate minutes or hours)

4a. How many times does your child wake up during the night? _____
4b. How long does it usually take your child to return to sleep? _____ (Indicate minutes or hours)
4c. My child is relatively ____ EASY or ____DIFFICULT (check one) to wake up in the morning.

5. How often does your child usually nap? ___ Never ___Little ___Weekly ___2-3 times/wk _____ Daily

6. Please describe any sleep comforts your child uses (e.g. blankets, plush toys or animals): _____

_____

SLEEP SYMPTOM DESCRIPTION

Please help us understand the nature of your child's sleep difficulties. Check any statement that applies:

1. _____My child snores
2. _____ My child's bed covers are very messed up in the morning
3. _____ My child tosses and turns at night and is a restless sleeper
4. _____ My child kicks, jerks, or has limb movements (arms or legs) during sleep
5. _____ My child has stopped breathing while asleep
6. _____ My child refuses to go to bed, sleep in their own bed or go to sleep without assistance
7. _____ My child wakes mid-sleep and cannot go back to sleep without assistance
8. _____ My child has frequent nightmares
9. _____ My child has frequent night terrors
10. _____ My child sleep walks… How many times per week on average? _____
11. _____ My child wets his/her bed… How many times per week on average? _____
12. _____ My child is excessively sleepy during the daytime.

Patient: Name:_____

EPWORTH SLEEPINESS SCALE FOR CHILDREN AND ADOLESCENTS (EES-CHAD)

Over the past month, how likely have you been to fall asleep while doing the things that are described below (activities)? Even if you haven't done some of these things in the past month, try to imagine how they would have affected you. Use the following scale to choose one number that best describes what has been happening to you during each activity over the past month. Write that number in the box below.

Chance of Falling Asleep	**0 = Never**	**1 = Slight Chance**	**2= Moderate chance**	**3 = High Chance**

Activity:	Chance of falling asleep (0-3)
1. Sitting and reading	_____
2. Sitting and watching TV or a video	_____
3. Sitting in a classroom at school during the morning	_____
4. Sitting and riding in a car or a bus for about half an hour	_____
5. Lying down to rest or nap in the afternoon	_____
6. Sitting and talking to someone	_____
7. Sitting quietly by yourself after lunch	_____
8. Sitting and eating a meal	_____

YOUR CHILD'S MEDICAL CONDITIONS

1. Please check all items that apply to your child:

___Easily distracted	___Hyperactive	___Anxiety or nervousness
___Overweight	___Underweight	___Bedwetting (if over 4 years of age)
___Asthma	___Sinus Problems	___Dizziness or passing out
___Headaches	___Seizures	___High blood pressure
___Chronic pain	___Depression	___Tonsillectomy/Adenoidectomy
___Heart problems	___Irregular heart beat	___Deviated septum/crooked or broken nose
___Developmental delay	___Learning disabilities	

2. Were the pregnancy and/or delivery with your child complicated? ___Yes ___No

If yes, describe:_____

_____

Was your child born on time? ___ Yes ___No If "No," how premature was your child? _____

4. Please describe any other medical conditions or current physical complaints:_____

_____

5. Please list all medications that your child takes, doses and time of administration: _____

_____

6. Has your child undergone any surgeries? If yes, please explain below: ___Yes ___No

_____

_____

7. Does your child have any allergies? If yes, please describe these below: ___Yes ____No

_____

_____

OTHER INFORMATION

1. Please describe any additional information you feel may affect your child's sleep:

_____

_____

2. Please describe any special needs your child may have, in particular any that may affect treatment or care with us:

_____

_____

FAMILY HISTORY

1. Does anyone else in your family have sleep problems? _____Yes _____No

If yes, describe their relationship to your child (e.g. mother, father, sister) and their condition

_____

_____