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

_____

_____

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SLEEP DIARY

Name: Week Of:

Day	Time Put to Bed	Time Fell Asleep	Nightime Waking (time/how long)	Describe Nighttime Waking	Time Awake	Describe Any Naps
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						

Sleep time/nap-time can be very challenging when a child resists going to sleep or when he is restless during sleep. As a parent or caregiver you have probably had difficulty settling you child down to sleep at one time or another. If you continue to have difficulty with settling your child down to sleep, even after following the suggestions from our “Bedtime Routines” or “Nap-time Routines” tip sheet, you may want to try keeping a Sleep Diary.

A Sleep Diary allows you to record information from every sleep routine that will help you to see any unusual patterns of sleep. The information you collect can help you identify or see where changes should be made in your child’s routine.

Let’s take a look at some things you’ll be recording in the Sleep Diary:

Keep track of these items for at least two weeks to find out about your child’s sleep pattern. Here are some things to consider when reviewing the completed

Sleep Diary:

- the amount of time it takes for your child to fall asleep (e.g., Does it take ten minutes or two hours?)
- how often, and for how long is your child’s sleep disrupted (e.g., How many times does your child wake up?)
- are night terrors keeping him awake?
- is your child not tired at nap-time?
- is the bedtime/nap-time routine interfering with your child’s ability to fall asleep on his own?
- information about the time your child wakes up every morning and naps during the day can reveal the total amount of sleep time – Is he getting enough sleep, too little sleep, or too much sleep?

Tracking this information will help you identify the type of sleep problem your child may be experiencing and will help you to begin to plan for change. Also, if you seek assistance from your child's pediatrician you can show them the Sleep Diary and he may be able to offer you suggestions to help solve your child's sleep problems.

Keep in mind that sleep problems are very common in children of all ages. A child may experience poor sleep during a brief period in their life, like holidays, a stressful event, or illness. For some children, not being able to settle down to sleep may occur only occasionally and for others it may be more chronic.

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CONSENT TO TREAT MINOR CHILDREN
Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to Sleep Study and/or EEG that has been determined by a physician to be necessary for the welfare of my child while said child is under the care of **National Sleep Solutions.**
This authorization is effective from _____ to _____.

For Minors older than 15 and/or less than 16)
Please initial the appropriate answer:

My child is driving to and from National Sleep Solutions _____Yes _____ No

If yes, please indicate drivers license information:_____. Initial_____

Must include copy of drivers license of child and drivers license of consenting parent.

_____
Signature of Parent or Legal Guardian

_____ _____
Witness Signature Witness Name (please print)

This Consent Form Should be Taken With the Child to the Hospital in Case of an Emergency

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family address

Telephone: Father _____ home _____ work
Mother _____ home _____ work

Child's Birthdate _____ Last Tetanus _____

Allergies to drugs or foods _____

Special Medications, Blood Type or Pertinent Information

_____

_____

Child's Physician _____ Phone _____

Insurance _____ Policy # _____

Preferred Hospital _____

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Cancellation/No Show Policy
for Doctor Appointments and Sleep Studies

1. **Cancellation/No Show Policy for Doctor Appointments**
   A $75 fee will be charged for all "no shows" or cancellations without 24 business hours notification; this fee is not covered by your insurance company or Medicare.

2. **Late Arrivals for Scheduled Appointments**
   If you arrive 15 minutes or more past your scheduled time, you may or may not be seen. At the discretion of the provider.

3. **Cancellation/ No Show Policy for Sleep Studies**
   If you need to cancel your scheduled sleep study, you must contact the sleep center during regular business hours 24 Business hours in advance. Please call by 5:00PM on Friday to cancel a Saturday/ Sunday/Monday night Study.

A $250 fee will be charged for all "no shows" or cancellations without 24 business hours notification; this fee is not covered by your insurance company or Medicare.

_____ _____

Name of Patient Signature and date

If signing for a minor;

_____ _____

Name of Parent or Caregiver Signature and date

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