Sleep, Breathing, & Habit Questionnaire

Patients Name: _____ Date: _____ Age: _____

Please indicate if child has these behaviors by using the scale below to indicate the severity of these symptoms.

1 - No occurrence **2 -** Very Rarely **3 -** Occurs 2-4 times a week

4 - Occurs 5-7 times a week **5 -** Occurs daily

Does Your Child:

1. _____ Snore at all

2. _____ Have labored, difficult, loud breathing at night

3. _____ Have interrupted snoring where breathing stops for 4 seconds

4. _____ Have stoppage of breathing more than 2 times in an hour

5. _____ Hyperactive

6. _____ Mouth breathes during day

7. _____ Mouth breathes while sleeping

8. _____ Frequent headaches in morning

9. _____ Allergic symptoms

10. _____ Excessive sweating while asleep

11. _____ Talks in sleep

12. _____ Struggles in Math at School

13. _____ Struggles in Reading at School

14. _____ Wakes up at night

15. _____ Attention deficit

16. _____ Restless sleep

17. _____ Grinds teeth

18. _____ Frequent throat infections

19. _____ Feels sleepy and/or irritable during the day

20. _____ Have a hard time listening and often interrupts

21. _____ Frequent Ear Infections

22. _____ Wet the bed

23. _____ Bluish color at night or during the day

24. _____ Have sensory issues

25. _____ Have avoidance behavior toward food or certain types of food

26. _____ Speech Problems *

**If yes, continue on to speech questionnaire in the section below*

Speech Questionnaire – to be filled out only if #26 was indicated above.

Please check all that apply to you or your child

- ☐ Is it difficult to understand your child's speech?
- ☐ Difficult to understand over the phone?
- ☐ Nasal speech?
- ☐ Hoarseness
- ☐ Speech sounds abnormal?
- ☐ Others have difficulty understanding speech?
- ☐ Sometimes omits consonants
- ☐ Gets frustrated when people can't understand speech?
- ☐ Uses M, N, NG instead of P, F, V, S, Z sounds
- ☐ Swallowing problems with liquids and solids getting into nose?