Riley Sleep Evaluation Questionnaire

(for parents of children ages 3 and older)

Shade circles like ● **Not** like ✗ ✓
Mark mistakes like ✗

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us better understand your child and his or her sleep problems.

Place hospital sticker here.

Questionnaire filled out by:

Relationship to patient:

CHILD'S INFORMATION

Child's Gender: ○ Male ○ Female

Child's racial/ethnic background: (check all that apply)

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Hispanic-Latino
- ☐ Asian
- ☐ Native American
- ☐ Other

What are your major concerns about your child's sleep? Please CHECK ALL that apply and PLACE A STAR NEXT TO YOUR MAIN CONCERN.

- ☐ Breathing problem during sleep (e.g. snoring)
- ☐ Feeling tired or sleepy during the day
- ☐ Restless movement during sleep
- ☐ Problems consistently getting enough sleep
- ☐ Problems falling or staying asleep
- ☐ Unusual episodes at night (e.g. sleepwalking)
- ☐ Leg pain or discomfort before bed
- ☐ Other (please describe below)

What have you tried to help your child's problem?

- ☐ Talking to my child's doctor about this
- ☐ Changing sleep habits (e.g. less caffeine)
- ☐ Sleep training approach (e.g. Ferber method)
- ☐ Over the counter herbal medication
- ☐ Other:
- ☐ Regular sleep routine
- ☐ Surgery for sleep apnea
- ☐ Prescription medication
- ☐ I have not tried anything

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Do you consider your child's sleep problem to be: ☐ No Problem ☐ Mild ☐ Moderate ☐ Severe

Who asked that your child be seen by a sleep specialist?

☐ Pediatrician/Family physician

☐ Neurologist

☐ Psychiatrist, Psychologist or other mental health professional

☐ Other pediatric specialist (e.g., allergist, pulmonolgist)

☐ Ear, Nose, and Throat Doctor

☐ Other

Child's Sleep History

Weekday Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period on weekdays (add daytime and nighttime sleep): ☐☐ hours ☐☐ minutes

The child's usual bedtime on weekday nights : ☐☐:☐☐

The child's usual waketime on weekday mornings : ☐☐:☐☐

Weekend Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period on weekends and vacations (add daytime and nighttime sleep): ☐☐ hours ☐☐ minutes

The child's usual bedtime on weekend/vacation nights : ☐☐:☐☐

The child's usual waketime on weekend/vacation mornings : ☐☐:☐☐

General Sleep

Number of naps child takes per day: ☐ 0 ☐ 1 ☐ 2 ☐ 3

Child falls asleep in school at times when others are not sleeping?	☐ Usually	☐ Sometimes	☐ Rarely	☐ N/A
Child naps after school?	☐ Usually	☐ Sometimes	☐ Rarely	☐ N/A
Child complains of leg pain?	☐ Usually	☐ Sometimes	☐ Rarely	☐ N/A

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The following statements are about your child's sleep habits and possible difficulties with sleep. Think about the past week in your child's life when answering these questions. If last week was unusual for a specific reason (such as your child was sick and did not sleep well), choose the most recent typical week. Answer USUALLY if something occurs 5 or more times in a week; answer SOMETIMES if it occurs 2-4 times in a week; answer RARELY if something occurs never or 1 time during a week.

	USUALLY (5-7 nights)	**SOMETIMES (2-4 nights)**	**RARELY (0-1 nights)**
1. Child goes to sleep at the same time at night	☐	☐	☐
2. Child falls asleep within 20 minutes after going to bed	☐	☐	☐
3. Child falls asleep in own bed	☐	☐	☐
4. Child falls asleep in parent's or sibling's bed	☐	☐	☐
5. Child needs parent in room to fall asleep	☐	☐	☐
6. Child struggles at bedtime (cries, refuses to stay in bed, etc.)	☐	☐	☐
7. Child is afraid of sleeping in the dark	☐	☐	☐
8. Child is afraid of sleeping alone	☐	☐	☐
9. Child sleeps too little	☐	☐	☐
10. Child sleeps the right amount	☐	☐	☐
11. Child sleeps about the same amount each day	☐	☐	☐
12. Child wets the bed at night	☐	☐	☐
13. Child talks during sleep	☐	☐	☐
14. Child is restless and moves a lot during sleep	☐	☐	☐
15. Child sleepwalks during the night	☐	☐	☐
16. Child moves to someone else's bed during the night (parent, brother, sister etc.)	☐	☐	☐
17. Child grinds teeth during sleep (dentist may have told you this)	☐	☐	☐
18. Child snores loudly	☐	☐	☐
19. Child seems to stop breathing during sleep	☐	☐	☐
20. Child snorts and/or gasps during sleep	☐	☐	☐
21. Child has trouble sleeping away from home (visiting relatives, vacation)	☐	☐	☐
22. Child awakens during the night screaming, sweating, and inconsolable	☐	☐	☐
23. Child awakens alarmed by a frightening dream	☐	☐	☐

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	USUALLY (5-7 nights)	SOMETIMES (2-4 nights)	RARELY (0-1 nights)
24. Child awakes once during the night	☐	☐	☐
25. Child awakes more than once during the night	☐	☐	☐
26. Child wakes up by him/herself	☐	☐	☐
27. Child wakes up in negative mood	☐	☐	☐
28. Adults or siblings wake up child	☐	☐	☐
29. Child has difficulty getting out of bed in the morning	☐	☐	☐
30. Child takes a long time to become alert in the morning	☐	☐	☐
31. Child seems tired	☐	☐	☐
32. Child shows repetitive actions such as rocking or headbanging while falling asleep?	☐	☐	☐
33. Child drinks caffeinated beverages (e.g. Coke, Mountain Dew, Tea)	☐	☐	☐

Daytime Sleepiness

How likely is your child to **doze off or fall asleep** in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if your child has not done some of these things recently, think about how they would have affected him or her.

	No Chance of Dozing	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
Sitting and Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting Inactive in a Public Place (e.g. movie theatre)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Medications

Please list any medications your child currently takes:

Medicine	Dose	How often?

☐ If you have more meds to enter, click here and write them on the last page.

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Child's Medical History

Please check all conditions your child **has now** or **has had in the past**

	Past	Now		Past	Now
Trouble breathing through his/her nose	☐	☐	Sickle cell disease	☐	☐
Chronic bronchitis or cough	☐	☐	Cranofacial disorder (e.g., Pierre-Robin)	☐	☐
Allergies	☐	☐	Thyroid problems	☐	☐
Asthma	☐	☐	Eczema (itchy skin)	☐	☐
Feeding problems	☐	☐	Chronic or persistent pain	☐	☐
Frequent strep throat infections	☐	☐	Trauma (e.g. abused, witnessed crime)	☐	☐
Infant apnea	☐	☐	Chromosome problem (e.g., Down's)	☐	☐
Acid reflux (gastroesophageal reflux)	☐	☐	Skeleton problem (e.g., dwarfism)	☐	☐
Poor or delayed growth	☐	☐	Autism	☐	☐
Excessive weight	☐	☐	Developmental delay	☐	☐
Hearing problems	☐	☐	Hyperactivity/ADHD	☐	☐
Speech problems	☐	☐	Anxiety/Panic Attacks	☐	☐
Vision problems	☐	☐	Obsessive Compulsive Disorder	☐	☐
Seizures/Epilepsy	☐	☐	Depression	☐	☐
Morning headaches	☐	☐	Behavioral disorder	☐	☐
Cerebral palsy	☐	☐	Learning disability	☐	☐
Heart disease	☐	☐	Drug use/abuse	☐	☐
High blood pressure	☐	☐	Psychiatric hospital admission	☐	☐

Please list any additional medical, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.

Pregnancy/Delivery

Pregnancy ☐ Normal ☐ Complications _____

Delivery ☐ Term ☐ Pre-term - How many weeks? ☐☐ Child's Birth Weight ☐☐ lb ☐☐ oz

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Surgeries / Hospitalizations

Has your child ever had his/her tonsils removed? ☐ No ☐ Yes Age at Surgery ☐☐

Reason for surgery:

Has your child ever had his/her adenoids removed? ☐ No ☐ Yes Age at Surgery ☐☐

Reason for surgery:

Has your child ever had ear tubes? ☐ No ☐ Yes Age at Surgery ☐☐

Reason for surgery:

Child's School Performance

Your child's grade: ☐☐ Has your child ever repeated a grade? ☐ No ☐ Yes

Is your child enrolled in any special education class? ☐ No ☐ Yes

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Family's Information

Mother

Age: ☐☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried

Highest Level of Education: ☐ Less than High School ☐ High School or GED Diploma ☐ Some College ☐ Bachelor's degree or higher

Occupation:

Father

Age: ☐☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried

Highest Level of Education: ☐ Less than High School ☐ High School or GED Diploma ☐ Some College ☐ Bachelor's degree or higher

Occupation:

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Smoking

Does your child smoke cigarettes?	☐ No	☐ Yes	☐ Not Sure	
Does anybody who lives in the home smoke cigarettes?	☐ No	☐ Yes, Inside the Home	☐ Yes, Outside only	
Are you interested in learning more about ways to help you or someone else quit smoking?	☐ No	☐ Yes	☐ Not Sure	

Family Sleep History

Does anyone in the family have a sleep disorder? ☐ No ☐ Yes

If yes, mark the disorder(s):

Insomnia	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Infant Apnea	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
SIDS	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent

THANK YOU for your time in completing this questionnaire. If there is any other information you would like us to know about your child or family, please write it in the space below.