Riley Sleep Evaluation Questionnaire

(For parents of children younger than age 3)

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 hospitcal 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

Where does your child usually sleep at night?
☐ Infant crib in a separate room ☐ Infant crib in parents' room
☐ In parents' bed ☐ Infant crib in room with sibling
☐ Other (please specify):

In what position does your child sleep most of the time?
☐ On his/her belly ☐ On his/her side ☐ On his/her back

How much time does your child spend sleeping during the NIGHT (between 7 in the evening and 7 in the morning)? ☐☐ hours ☐☐ minutes

How much time does your child spend sleeping during the DAY (between 7 in the morning and 7 in the evening)? ☐☐ hours ☐☐ minutes

What is the average number of times your child wakes during the night? ☐☐

How much time during the night does your child spend awake (from 10 in the evening to 6 in the morning)? ☐☐ hours ☐☐ minutes

How long does it take to put your child to sleep in the evening? ☐☐ hours ☐☐ minutes

How does your child fall asleep?
☐ While feeding ☐ In bed near parent
☐ Being held ☐ Being rocked
☐ In bed alone
☐ Other (please specify):

What time does your child usually fall asleep for the night? ☐☐:☐☐

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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 struggles at bedtime (cries, refuses to stay in bed, etc.)	☐	☐	☐
3. Child sleeps too little	☐	☐	☐
4. Child sleeps the right amount	☐	☐	☐
5. Child sleeps about the same amount each day	☐	☐	☐
6. Child is restless and moves a lot during sleep	☐	☐	☐
7. Child grinds teeth during sleep (dentist may have told you this)	☐	☐	☐
8. Child snores loudly	☐	☐	☐
9. Child seems to stop breathing during sleep	☐	☐	☐
10. Child snorts and/or gasps during sleep	☐	☐	☐
11. Child awakens during the night screaming, sweating, and inconsolable	☐	☐	☐
12. Child awakes once during the night	☐	☐	☐
13. Child awakes more than once during the night	☐	☐	☐
14. Child wakes up by him/herself	☐	☐	☐
15. Child wakes up in negative mood	☐	☐	☐
16. Adults or siblings wake up child	☐	☐	☐
17. Child takes a long time to become alert in the morning	☐	☐	☐
18. Child seems tired	☐	☐	☐
19. Child shows repetitive actions such as rocking or headbanging while falling asleep?	☐	☐	☐

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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:

Birth order of the child being seen today: ☐ Oldest ☐ Middle ☐ Youngest

Smoking

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

Medications

Please list any medications your child currently takes:

Medicine	Dose	How often?

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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	☐	☐	Cranofacialdisorder (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 or worries	☐	☐
Vision problems	☐	☐	Behavioral disorder	☐	☐
Seizures/Epilepsy	☐	☐	Heart disease	☐	☐
Morning headaches	☐	☐	High blood pressure	☐	☐
Cerebral palsy	☐	☐			

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:

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.