# PEDIATRIC SLEEP EVALUATION QUESTIONNAIRE

**Directions**: Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

Date: _____

## CHILD'S INFORMATION

Child's Name: _____ Child's Gender: ☐ Male ☐ Female

Child's Birthdate: _____ Child's Age: _____

Child's Racial/Ethnic Background: ☐ White/Caucasian ☐ Black/African-American
☐ Native-American ☐ Hispanic-Latino
☐ Multi-racial ☐ Other

What are your major concerns about your child's sleep? _____

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

# 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): _____hrs. ____mins.

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

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

**Weekend/Vacation Sleep Schedule**

Write in the amount of time child sleeps during a 24-hour period during weekends/vacations (add daytime and nighttime sleep): _____hrs. ____mins.

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

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

**Nap Schedule**

Number of days each week child takes a nap: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5

If child naps, write in usual nap time(s): Nap1: _____ : _____ □ a.m. □ p.m. to _____:_____ □ a.m. □ p.m.

Nap2: _____ : _____ □ a.m. □ p.m. to _____:_____ □ a.m. □ p.m.

**General Sleep**

Does the child have a regular bedtime routine? □ yes □ no

Does the child have his/her own bedroom? □ yes □ no

Does the child have his/her own bed? □ yes □ no

Is the parent present when your child falls asleep? □ yes □ no

| Child usually falls asleep in | Child sleeps most of the night in | Child usually wakes in the morning in |
|---|---|---|
| □ own room in own bed (alone) | □ own room in own bed (alone) | □ own room in own bed (alone) |
| □ parents' room in own bed | □ parents' room in own bed | □ parents' room in own bed |
| □ parents' room in parents' bed | □ parents' room in parents' bed | □ parents' room in parents' bed |
| □ sibling's room in own bed | □ sibling's room in own bed | □ sibling's room in own bed |
| □ sibling's room in sibling's bed | □ sibling's room in sibling's bed | □ sibling's room in sibling's bed |

Child is usually put to bed by: □ Mother □ Father □ Both Parents □ Self □ Others

Write in the amount of time the child spends in his/her bedroom before going to sleep: _____ minutes.

Child resists going to bed? □ yes □ no **If yes**, do you think this is a problem? □ yes □ no

Child has difficulty falling asleep? □ yes □ no **If yes**, do you think this is a problem? □ yes □ no

Child awakens during the night? ☐ yes ☐ no **If yes**, do you think this is a problem? ☐ yes ☐ no

After nighttime awakening, Child has difficulty falling back to sleep? ☐ yes ☐ no **If yes**, do you think this is a problem? ☐ yes ☐ no

Child is difficult to awaken in the Morning? ☐ yes ☐ no **If yes**, do you think this is a problem? ☐ yes ☐ no

Child is a poor sleeper? ☐ yes ☐ no **If yes**, do you think this is a problem? ☐ yes ☐ no

**Current Sleep Symptoms**

(a) = never, (b) = not often (less than 1 night/day a week) (c) = sometimes (1 to 2 nights/days a week)
(d) = often (3 to 5 nights/days a week (e) = always (6 to 7 nights/days a week)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Difficulty breathing when asleep | a | b | c | d | e | f |
| 2. | Stops breathing during sleep | a | b | c | d | e | f |
| 3. | Snores | a | b | c | d | e | f |
| 4. | Restless sleep | a | b | c | d | e | f |
| 5. | Sweating when sleeping | a | b | c | d | e | f |
| 6. | Daytime sleepiness | a | b | c | d | e | f |
| 7. | Poor appetite | a | b | c | d | e | f |
| 8. | Nightmares | a | b | c | d | e | f |
| 9. | Sleepwalking | a | b | c | d | e | f |
| 10. | Sleeptalking | a | b | c | d | e | f |
| 11. | Screaming in his/her sleep | a | b | c | d | e | f |
| 12. | Kicks legs in sleep | a | b | c | d | e | f |
| 13. | Wakes up at night | a | b | c | d | e | f |
| 14. | Gets out of bed at night | a | b | c | d | e | f |
| 15. | Trouble staying in his/her bed | a | b | c | d | e | f |
| 16. | Resists going to bed at bedtime | a | b | c | d | e | f |
| 17. | Grinds his/her teeth | a | b | c | d | e | f |
| 18. | Uncomfortable feeling in his/her legs; creepy-crawly feeling | a | b | c | d | e | f |
| 19. | Wets bed | a | b | c | d | e | f |

**Current Daytime Symptoms**

(b) = never, (b) = not often (less than 1 night/day a week) (c) = sometimes (1 to 2 nights/days a week)
(d) = often (3 to 5 nights/days a week (e) = always (6 to 7 nights/days a week)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Trouble getting up in the morning | a | b | c | d | e | f |
| 2. | Falls asleep in school | a | b | c | d | e | f |
| 3. | Naps after school | a | b | c | d | e | f |
| 4. | Daytime sleepiness | a | b | c | d | e | f |
| 5. | Feels weak or loses control of his/her muscles with strong emotions | a | b | c | d | e | f |
| 6. | Reports unable to move when falling asleep or upon waking | a | b | c | d | e | f |
| 7. | Sees frightening visual images before falling asleep or upon waking. | a | b | c | d | e | f |

**Pregnancy/Delivery**

Pregnancy: ☐ Normal ☐ Difficult

Delivery ☐ Term ☐ Pre-term ☐ Post-term

Child's birthweight: _____

Only child? ☐ Yes ☐ No If no, circle birth order: 1st 2nd 3rd 4th 5th 6th 7th

# MEDICAL AND PSYCHIATRIC HISTORY

## PAST MEDICAL HISTORY

| | | | |
|---|---|---|---|
| Frequent nasal congestion | ☐ Yes | Age of diagnosis: | |
| Trouble breathing through his/her nose | ☐ Yes | Age of diagnosis: | |
| Sinus problems | ☐ Yes | Age of diagnosis: | |
| Chronic bronchitis or cough | ☐ Yes | Age of diagnosis: | |
| Allergies | ☐ Yes | Age of diagnosis: | Allergic to what: |
| Asthma | ☐ Yes | Age of diagnosis: | |
| Frequent colds or flus | ☐ Yes | Age of diagnosis: | |
| Frequent ear infections | ☐ Yes | Age of diagnosis: | |
| Frequent strep throat infections | ☐ Yes | Age of diagnosis: | |
| Difficulty swallowing | ☐ Yes | Age of diagnosis: | |
| Acid reflux (gastroesophageal reflux) | ☐ Yes | Age of diagnosis: | |
| Poor or delayed growth | ☐ Yes | Age of diagnosis: | |
| Excessive weight | ☐ Yes | Age of diagnosis: | |
| Hearing problems | ☐ Yes | Age of diagnosis: | |
| Speech problems | ☐ Yes | Age of diagnosis: | |
| Vision problems | ☐ Yes | Age of diagnosis: | |
| Seizures/Epilepsy | ☐ Yes | Age of diagnosis: | |
| Morning headaches | ☐ Yes | Age of diagnosis: | |
| Cerebral palsy | ☐ Yes | Age of diagnosis: | |
| Heart disease | ☐ Yes | Age of diagnosis: | |
| High blood pressure | ☐ Yes | Age of diagnosis: | |
| Sickle cell disease | ☐ Yes | Age of diagnosis: | |
| Genetic disease | ☐ Yes | Age of diagnosis: | |
| Chromosome problem (e.g., Down's) | ☐ Yes | Age of diagnosis: | |
| Skeleton problem (e.g., dwarfism) | ☐ Yes | Age of diagnosis: | |
| Craniofacial disorder (e.g., Pierre-Robin) | ☐ Yes | Age of diagnosis: | |
| Thyroid problems | ☐ Yes | Age of diagnosis: | |
| Eczema (itchy skin) | ☐ Yes | Age of diagnosis: | |
| Pain | ☐ Yes | Age of diagnosis: | |

## PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

| | | |
|---|---|---|
| Autism | ☐ Yes | Age of diagnosis: |
| Developmental delay | ☐ Yes | Age of diagnosis: |
| Hyperactivity/ADHD | ☐ Yes | Age of diagnosis: |
| Anxiety/Panic Attacks | ☐ Yes | Age of diagnosis: |
| Obsessive Compulsive Disorder | ☐ Yes | Age of diagnosis: |
| Depression | ☐ Yes | Age of diagnosis: |
| Suicide | ☐ Yes | Age of diagnosis: |
| Learning disability | ☐ Yes | Age of diagnosis: |
| Drug use/abuse | ☐ Yes | Age of diagnosis: |
| Behavioral disorder | ☐ Yes | Age of diagnosis: |
| Psychiatric Admission | ☐ Yes | Age of diagnosis: |

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

## CURRENT MEDICAL HISTORY

Please list any medications your child currently takes:

| **Medicine** | **Dose** | **How often?** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## LONG-TERM MEDICAL PROBLEMS

If your child has long-term medical problems, please list the three you think are most important.

1. _____
2. _____
3. _____

## SURGERIES/HOSPITALIZATIONS

Has your child ever had his/her tonsils removed? ☐ Yes Age of surgery:

Has our child ever had his/her adenoids removed? ☐ Yes Age of surgery:

Has our child ever had ear tubes? ☐ Yes Age of surgery:

Please list any additional hospitalizations or surgeries: _____

## HEALTH HABITS

Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea) ☐ Yes ☐ No Amount per day:

## SCHOOL PERFORMANCE

### CURRENT SCHOOL PERFORMANCE (if school-aged)

Your child's grade: _____

Has your child ever repeated a grade? ☐ Yes ☐ No

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

How many school days has your child missed so far this year? _____

How many school days did your child miss last year? _____

How many school days was your child last so far this year? _____

How many school days was your child last year? _____

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

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

## FAMILY'S INFORMATION

| MOTHER | FATHER |
|---|---|
| Age: _____ | Age: _____ |
| Martial Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried | ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried |
| Education: _____ | Education: _____ |
| Work: ☐ Unemployed ☐ Part-time ☐ Full-time | Work: ☐ Unemployed ☐ Part-time ☐ Full-time |
| Occupation: _____ | Occupation: _____ |

### PERSONS LIVING IN HOME

| Name: | Relationship: | Age: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### FAMILY SLEEP HISTORY

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

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 |
| Periodic limb movement disorder | ☐ Mother | ☐ Father | ☐ Brother/Sister | ☐ Grandparent |
| Sleepwalking/sleep terrors | ☐ Mother | ☐ Father | ☐ Brother/Sister | ☐ Grandparent |
| Sleep talking | ☐ Mother | ☐ Father | ☐ Brother/Sister | ☐ Grandparent |
| Narcolepsy | ☐ Mother | ☐ Father | ☐ Brother/Sister | ☐ Grandparent |
| Other: | ☐ Mother | ☐ Father | ☐ Brother/Sister | ☐ Grandparent |

**REFERRAL**

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

- ☐ Pediatrician/Family physician
- ☐ Child's parent or guardian
- ☐ Surgical specialist (e.g., ENT)
- ☐ Pediatric specialist (e.g., allergist, neurologist, pulmonologist)
- ☐ Mental health specialist (e.g., psychiatrist, psychologist, social worker)
- ☐ School teach, nurse, counselor
- ☐ Child himself/herself
- ☐ Other: _____

# SCREENING QUESTIONNAIRE:
## Obstructive Sleep Apnea

Child's Name: _____ Date: _____

Person completing form: _____ Relation: _____

Please answer the following questions as they pertain to your child in the past month.

1. While sleeping, does your child:
   a. Snore more than half the time? ☐ Yes ☐ No ☐ Unknown
   b. Always snore? ☐ Yes ☐ No ☐ Unknown
   c. Snore loudly? ☐ Yes ☐ No ☐ Unknown
   d. Have "heavy" or loud breathing? ☐ Yes ☐ No ☐ Unknown
2. Have you ever seen our child stop breathing during The night? ☐ Yes ☐ No ☐ Unknown
3. Does your child:
   a. Tend to breath through the mouth during the day? ☐ Yes ☐ No ☐ Unknown
   b. Have a dry mouth on waking up in the morning? ☐ Yes ☐ No ☐ Unknown
   c. Occasionally wet the bed? ☐ Yes ☐ No ☐ Unknown
4. Does your child:
   a. Wake up feeling unrefreshed in the morning? ☐ Yes ☐ No ☐ Unknown
   b. Have a problem with sleepiness during the day? ☐ Yes ☐ No ☐ Unknown
5. Has a teacher or other supervisor commented that your Child appears sleepy during the day? ☐ Yes ☐ No ☐ Unknown
6. Is it hard to wake your child up in the mooring? ☐ Yes ☐ No ☐ Unknown
7. Does your child wake up with headaches in the morning? ☐ Yes ☐ No ☐ Unknown
8. Did your child stop growing at a normal rate at any time since birth? ☐ Yes ☐ No ☐ Unknown

9. Is your child overweight? ☐ Yes ☐ No ☐ Unknown

10. This child *often*:

a. Does not seem to listen when spoken to directly ☐ Yes ☐ No ☐ Unknown

b. Has difficulty organizing tasks and activities ☐ Yes ☐ No ☐ Unknown

c. Is easily distracted by extraneous stimuli ☐ Yes ☐ No ☐ Unknown

d. Fidgets with hands or feet or squirms in seat ☐ Yes ☐ No ☐ Unknown

e. Does not seem to listen when spoken to directly ☐ Yes ☐ No ☐ Unknown

f. Is "on the go" or often acts as if "driven by a motor" ☐ Yes ☐ No ☐ Unknown

g. Interrupts or intrudes on others (e.g., butts into conversations or games) ☐ Yes ☐ No ☐ Unknown

Scoring

Yes = 1
No = 0

Average all scores to obtain a score between 0.00 and 1.00. Preliminary analyses suggest a cut-off of > 0.33 for abnormal.

(*For more information see Chervin RD, Hedger K, Dillon JE, Pituch KJ (2000). Pediatric Sleep Questionnaire (PSQ): validity and reliability of scales for sleep-disordered breathing, snoring, sleepiness, and behavioral problems. Sleep Medicine 1:21-32.*)

# SCREENING QUESTIONNAIRE:
## Restless Legs Syndrome
## (Parent Version)

Child's Name: _____ Date: _____

Person completing form: _____ Relation: _____

1. Does your child have "growing pains"? (Check One)

□ Never □ Occasionally (less than 1x/month) □ sometimes (1-2x/month) □ frequently (1-2x/wk to daily)

2. Does your child complain of uncomfortable or funny feelings (creeping, crawling, tingling) in his/her legs? (Check One)

□ Never □ Occasionally (less than 1x/month) □ sometimes (1-2x/month) □ frequently (1-2x/wk to daily)

3. Does your child:
   a. Notice funning feelings in his/her legs (or do they seem worse) when lying down Or sitting? □ Yes □ No □ Unknown
   b. Have partial relief with movement (wiggling feet, toes, or walking?) □ Yes □ No □ Unknown
   c. Complain that the feelings are worse at night?? □ Yes □ No □ Unknown
   d. Have a lot of fidgeting or wiggling of the feet or toes when sitting or lying down? □ Yes □ No □ Unknown

4. Does your child appear restless while sleeping (thrashing around, banging feet against wall, twisting covers, or falling out of bed)? (Check one)

□ Never □ Occasionally (less than 1x/month) □ sometimes (1-2x/month) □ frequently (1-2x/wk to daily)

5. Does your child seem more restless, fidgety or hyperactive than most children his/her age?

□ Never □ Occasionally (less than 1x/month) □ sometimes (1-2x/month) □ frequently (1-2x/wk to daily)

6. Has anyone in the family (including grandparents, aunts/uncles) been diagnosed with restless legs or periodic leg movements during sleep?

   □ Yes □ No If so, who: _____

7. Does anyone in the family have severe problems falling or staying asleep?

□ Yes □ No If so, who: _____

8. How often, on average, does your child consume caffeine-containing beverages or food? (coffee, tea, cola beverages, chocolate)

□ Never □ Occasionally (less than 1x/month) □ sometimes (1-2x/month) □ frequently (1-2x/wk to daily)

9. Has your child ever been diagnosed and/or treated for anemia?

□ Yes □ No □ Unknown If so, date, type of anemia, and treatment: _____