PEDIATRIC SLEEP QUESTIONNAIRE

Version 070424

Child's Name: _____, _____ _____.
(Last) (First) (M.I.)

Name of Person Answering Questions: _____.

Relation to Child: _____.

Your phone number, days: _____, and evenings: _____.
Area Code Number Area Code Number

Relative's name and number in case we cannot reach you: _____.

_____ _____.
Area Code Number

Instructions:

Please answer the questions on the following pages regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general, not necessarily during the past few days since these may not have been typical if your child has not been well. If you are not sure how to answer any question, please feel free to ask your husband or wife, child, or physician for help. You should circle the correct response or *print* your answers neatly in the space provided. A "Y" means "yes," "N" means "no," and "DK" means "don't know." When you see the word "usually" it means "more than half the time" or "on more than half the nights."

GENERAL INFORMATION ABOUT YOUR CHILD:

Office use only
GI1
GI2
GI3
GI4
GI5
GI6
GI7
GI8
GI9

Today's Date: _____.
Month Day Year

Where are you completing this questionnaire? _____.

Date of Child's Birth: _____.
Month Day Year

Sex: Male or Female? _____.

Current Height (feet/inches) : _____.

Current Weight (pounds) : _____.

Grade in school (if applicable):_____.

Racial/Ethnic Background of your Child (please circle):

1.) American Indian **2.) Asian-American**

3.) African-American **4.) Hispanic**

5.) White/not Hispanic **6.) Other or unknown**

A. Nighttime and sleep behavior: WHILE SLEEPING, DOES YOUR CHILD …		Office use only
… ever snore?	Y N DK	A1
… snore more than half the time?	Y N DK	A2
… always snore?	Y N DK	A3
… snore loudly?	Y N DK	A4
… have "heavy" or loud breathing?	Y N DK	A5
… have trouble breathing, or struggle to breathe? HAVE YOU EVER …	Y N DK	A6
… seen your child stop breathing during the night? If so, please describe what has happened:	Y N DK	A7
… been concerned about your child's breathing during sleep?	Y N DK	A8
… had to shake your sleeping child to get him or her to breathe, or wake up and breathe?	Y N DK	A9
… seen your child wake up with a snorting sound? DOES YOUR CHILD …	Y N DK	A11
… have restless sleep?	Y N DK	A12
… describe restlessness of the legs when in bed?	Y N DK	A13
… have "growing pains" (unexplained leg pains)?	Y N DK	A13a
… have "growing pains" that are worst in bed? WHILE YOUR CHILD SLEEPS, HAVE YOU SEEN …	Y N DK	A13b
… brief kicks of one leg or both legs?	Y N DK	A14
… repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)? AT NIGHT, DOES YOUR CHILD USUALLY …	Y N DK	A14a
… become sweaty, or do the pajamas usually become wet with perspiration?	Y N DK	A15
… get out of bed (for any reason)?	Y N DK	A16

… get out of bed to urinate? If so, how many times each night, on average?	Y N DK _____ times	A17 A17a
Does your child usually sleep with the mouth open?	Y N DK	A21
Is your child's nose usually congested or "stuffed" at night?	Y N DK	A22
Do any allergies affect your child's ability to breathe through the nose?	Y N DK	A23
DOES YOUR CHILD …		
… tend to breathe through the mouth during the day?	Y N DK	A24
… have a dry mouth on waking up in the morning?	Y N DK	A25
… complain of an upset stomach at night?	Y N DK	A27
… get a burning feeling in the throat at night?	Y N DK	A29
… grind his or her teeth at night?	Y N DK	A30
… occasionally wet the bed?	Y N DK	A32
Has your child ever walked during sleep ("sleep walking")?	Y N DK	A33
Have you ever heard your child talk during sleep ("sleep talking")?	Y N DK	A34
Does your child have nightmares once a week or more on average?	Y N DK	A35
Has your child ever woken up screaming during the night?	Y N DK	A36
Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep? If so, please describe what has happened:	Y N DK	A37
Does your child have difficulty falling asleep at night?	Y N DK	A40
How long does it take your child to fall asleep at night? (a guess is O.K.)	_____ minutes	A41
At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly?	Y N DK	A42
DOES YOUR CHILD … … bang his or her head or rock his or her body when going to sleep?	Y N DK	A43
… wake up more than twice a night on average?	Y N DK	A44
… have trouble falling back asleep if he or she wakes up at night?	Y N DK	A45

… wake up early in the morning and have difficulty going back to sleep?	Y N DK	A46
Does the time at which your child goes to bed change a lot from day to day?	Y N DK	A47
Does the time at which your child gets up from bed change a lot from day to day? WHAT TIME DOES YOUR CHILD USUALLY …	Y N DK	A48
… go to bed during the week?		A49
… go to bed on the weekend or vacation?		A50
… get out of bed on weekday mornings?		A51
… get out of bed on weekend or vacation mornings?		A52

B. Daytime behavior and other possible problems: DOES YOUR CHILD …		Office Use Only
… wake up feeling unrefreshed in the morning?	Y N DK	B1
… have a problem with sleepiness during the day?	Y N DK	B2
… complain that he or she feels sleepy during the day?	Y N DK	B3
Has a teacher or other supervisor commented that your child appears sleepy during the day?	Y N DK	B4
Does your child usually take a nap during the day?	Y N DK	B5
Is it hard to wake your child up in the morning?	Y N DK	B6
Does your child wake up with headaches in the morning?	Y N DK	B7
Does your child get a headache at least once a month, on average?	Y N DK	B8
Did your child stop growing at a normal rate at any time since birth? If so, please describe what happened:	Y N DK	B9
Does your child still have tonsils? If not, when and why were they removed?: HAS YOUR CHILD EVER …	Y N DK	B10
… had a condition causing difficulty with breathing?	Y N DK	B11

If so, please describe:		
… had surgery? **If so, did any difficulties with breathing occur before, during, or after surgery?**	**Y N DK** **Y N DK**	B12 B12a
… become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?	**Y N DK**	B13
… felt unable to move for a short period, in bed, though awake and able to look around?	**Y N DK**	B15
Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?	**Y N DK**	B16
Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?	**Y N DK**	B17
Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)? **If so, how many cups or cans per day?**	**Y N DK** _____ **cups**	B18 B18a
Does your child use any recreational drugs? **If so, which ones and how often?:**	**Y N DK**	B19
Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products? If so, which ones and how often?:	**Y N DK**	B20
Is your child overweight? **If so, at what age did this first develop?**	**Y N DK** _____ **years**	B22 B22a
Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?	**Y N DK**	B23
Has your child ever taken Ritalin (methylphenidate) for behavioral problems?	**Y N DK**	B24
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?	**Y N DK**	B25

C. Other Information

1. If you are currently at a clinic with your child to see a physician, what is the problem that brought you?

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

_____.

_____.

_____.

3. Please list any medications your child currently takes:

Medicine	Size (mg) or amount per dose	Taken when?
_____	_____	_____
Effect:	_____.	
_____	_____	_____
Effect:	_____.	
_____	_____	_____
Effect:	_____.	
_____	_____	_____
Effect:	_____.	

4. Please list any medication your child has taken in the past if the purpose of the medication was to improve his or her behavior, attention, or sleep:

Medicine	Size (mg) or amount per dose	Taken how often?	Dates Taken
_____	_____	_____	_____
Effect:	_____		
_____	_____	_____	_____
Effect:	_____		
_____	_____	_____	_____
Effect:	_____		
_____	_____	_____	_____
Effect:	_____		

5. Please list any sleep disorders diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

6. Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

7. Please list any sleep or behavior disorders diagnosed or suspected in *your child's* brothers, sisters, or parents:

Relative	**Condition**
_____	_____
_____	_____
_____	_____

D. Additional Comments:

Please use the space below to print any additional comments you feel are important. Please also use this space to describe details regarding any of the above questions.

Instructions:

Please indicate, by checking the appropriate box, how much each statement* applies to this child:

This child often…	Does not apply 0	Applies just a little 1	Applies quite a bit 2	Definitely applies most of the time 3
… does not seem to listen when spoken to directly.				
… has difficulty organizing tasks and activities.				
… is easily distracted by extraneous stimuli.				
… fidgets with hands or feet or squirms in seat.				
… is "on the go" or often acts as if "driven by a motor".				
… interrupts or intrudes on others (e.g., butts into conversations or games.				

* Derived from DSM-IV.

THANK YOU