

# Health and Sleep Questionnaire

## 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.

CHILD'S INFORMATION	
Child's name:	Child's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's birthdate:	Child's age:
Child's racial/ethnic background:	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian American <input type="checkbox"/> Native-American <input type="checkbox"/> Hispanic-Latino <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other

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

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

SLEEP HISTORY	
<b>Weekday Sleep Schedule</b>	
Write in the amount of time child sleeps during a 24-hour period <i>on weekdays</i> (add daytime and nighttime sleep):	_____ hours _____ minutes
The child's usual bedtime on <i>weekday nights</i> :	_____ : _____
The child's usual <i>waketime</i> on <i>weekday mornings</i> :	_____ : _____

<b>Weekend/Vacation Sleep Schedule</b>		
Write in the amount of time child sleeps during a 24-hour period <i>during weekends and vacations</i> (add daytime and nighttime sleep):		_____ hours _____ minutes
The child's usual bedtime on <i>weekend/vacation nights</i> :		_____ : _____
The child's usual <i>waketime on weekend/vacation mornings</i> :		_____ : _____
<b>Nap Schedule</b>		
Number of <i>days each week</i> child takes a nap: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		
If child naps, write in usual nap time(s):		
Nap 1: _____ : _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. to _____ : _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
Nap 2: _____ : _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. to _____ : _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
<b>General Sleep</b>		
Does the child have a regular bedtime routine?		<input type="checkbox"/> yes <input type="checkbox"/> no
Does the child have his/her own bedroom?		<input type="checkbox"/> yes <input type="checkbox"/> no
Does the child have his/her own bed?		<input type="checkbox"/> yes <input type="checkbox"/> no
Is a parent present when your child falls asleep?		<input type="checkbox"/> yes <input type="checkbox"/> no
Child usually <i>falls asleep</i> in ...	Child <i>sleeps most of the night</i> in ...	Child usually <i>wakes in the morning</i> in ...
<input type="checkbox"/> own room in own bed (alone)	<input type="checkbox"/> own room in own bed (alone)	<input type="checkbox"/> own room in own bed (alone)
<input type="checkbox"/> parents' room in own bed	<input type="checkbox"/> parents' room in own bed	<input type="checkbox"/> parents' room in own bed
<input type="checkbox"/> parents' room in parent's bed	<input type="checkbox"/> parents' room in parent's bed	<input type="checkbox"/> parents' room in parent's bed
<input type="checkbox"/> sibling's room in own bed	<input type="checkbox"/> sibling's room in own bed	<input type="checkbox"/> sibling's room in own bed
<input type="checkbox"/> sibling's room in sibling's bed	<input type="checkbox"/> sibling's room in sibling's bed	<input type="checkbox"/> sibling's room in sibling's bed
Child is usually put to bed by: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Parents <input type="checkbox"/> Self <input type="checkbox"/> Others		
Write in the <i>amount of time</i> the child spends in <i>his/her bedroom</i> before going to sleep: _____ minutes		
Child resists going to bed? <input type="checkbox"/> yes <input type="checkbox"/> no <b>If yes, do you think this is a problem?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		
Child has difficulty falling asleep? <input type="checkbox"/> yes <input type="checkbox"/> no <b>If yes, do you think this is a problem?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		
Child awakens during the night? <input type="checkbox"/> yes <input type="checkbox"/> no <b>If yes, do you think this is a problem?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		
After nighttime awakening, child has difficulty falling back to sleep? <input type="checkbox"/> yes <input type="checkbox"/> no <b>If yes, do you think this is a problem?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		
Child is difficult to awaken in the morning? <input type="checkbox"/> yes <input type="checkbox"/> no <b>If yes, do you think this is a problem?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		
Child is a poor sleeper? <input type="checkbox"/> yes <input type="checkbox"/> no <b>If yes, do you think this is a problem?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		

<b>Current Sleep Symptoms</b>						
	(a) never (does not happen)	(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)	(f) do not know
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. Sleepwalking	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

<b>Current Daytime Symptoms</b>						
	(a) never (does not happen)	(b) not often (less than 1 days a week)	(c) sometimes (1 to 2 days a week)	(d) often (3 to 5 days a week)	(e) always (6 to 7 days a week)	(f) do not know
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  DifficultDelivery  Term  Pre-term  Post-termChild'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: Allergies to what:Asthma  Yes Age of diagnosis:

Frequent colds or flus	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent ear infections	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent strep throat infections	<input type="checkbox"/> Yes	Age of diagnosis:
Difficulty swallowing	<input type="checkbox"/> Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux?)	<input type="checkbox"/> Yes	Age of diagnosis:
Poor or delayed growth	<input type="checkbox"/> Yes	Age of diagnosis:
Excessive weight	<input type="checkbox"/> Yes	Age of diagnosis:
Hearing problems	<input type="checkbox"/> Yes	Age of diagnosis:
Speech problems	<input type="checkbox"/> Yes	Age of diagnosis:
Vision problems	<input type="checkbox"/> Yes	Age of diagnosis:
Seizures/Epilepsy	<input type="checkbox"/> Yes	Age of diagnosis:
Morning headaches	<input type="checkbox"/> Yes	Age of diagnosis:
Cerebral palsy	<input type="checkbox"/> Yes	Age of diagnosis:
Heart disease	<input type="checkbox"/> Yes	Age of diagnosis:
High blood pressure	<input type="checkbox"/> Yes	Age of diagnosis:
Sickle cell disease	<input type="checkbox"/> Yes	Age of diagnosis:
Genetic disease	<input type="checkbox"/> Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	<input type="checkbox"/> Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	<input type="checkbox"/> Yes	Age of diagnosis:
Craniofacial disorder (e.g., Pierre-Robin)	<input type="checkbox"/> Yes	Age of diagnosis:
Thyroid problems	<input type="checkbox"/> Yes	Age of diagnosis:
Eczema (itchy skin)	<input type="checkbox"/> Yes	Age of diagnosis:
Pain	<input type="checkbox"/> Yes	Age of diagnosis:
<b>PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY</b>		
Autism	<input type="checkbox"/> Yes	Age of diagnosis:
Developmental delay	<input type="checkbox"/> Yes	Age of diagnosis:
Hyperactivity/ADHD	<input type="checkbox"/> Yes	Age of diagnosis:
Anxiety/Panic Attacks	<input type="checkbox"/> Yes	Age of diagnosis:
Obsessive Compulsive Disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Depression	<input type="checkbox"/> Yes	Age of diagnosis:
Suicide	<input type="checkbox"/> Yes	Age of diagnosis:
Learning disability	<input type="checkbox"/> Yes	Age of diagnosis:
Drug use/abuse	<input type="checkbox"/> Yes	Age of diagnosis:
Behavioral disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Psychiatric Admission	<input type="checkbox"/> 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:			
1.						
2.						
3.						
4.						
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?		<input type="checkbox"/> Yes	Age of surgery:			
Has your child ever had his/her adenoids removed?		<input type="checkbox"/> Yes	Age of surgery:			
Has your child ever had ear tubes?		<input type="checkbox"/> 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)						
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Amount per day:			
SCHOOL PERFORMANCE						
CURRENT SCHOOL PERFORMANCE (if school-aged)						
Your child's grade:						
Has your child ever repeated a grade?		<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Is your child enrolled in any special education class?		<input type="checkbox"/> No	<input type="checkbox"/> Yes			
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 late so far this year?						
How many school days was your child late last year?						
Child's grades this year:		<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Poor	<input type="checkbox"/> Failing
Child's grades last year:		<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Poor	<input type="checkbox"/> Failing

FAMILY'S INFORMATION		
MOTHER	FATHER	
Age	Age	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried	
Education:	Education:	
Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	
Occupation:	Occupation:	
PERSONS LIVING IN HOME		
Name	Relationship	Age
FAMILY SLEEP HISTORY		
Does anyone in the family have a sleep disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, mark the disorder(s):		
Insomnia	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Snoring	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Sleep apnea	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Restless legs syndrome	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Periodic limb movement disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Sleepwalking/sleep terrors	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Sleep talking	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Narcolepsy	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Other:	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent