Dr. Joshua Rotenberg, Dr. Sarat Susarla, Kara Schmidt PA, RD

Pediatric Sleep Evaluation Questionnaire

Patient Name: ____

Date of Birth: _________/_________/_________

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 history and your child.

Child's Information

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

____
____
____
____

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

____
____
____
____

Current Daytime Symptoms

(a) Never-does not happen
(b) Not often (less than 1 day 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

Please circle one:

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	a	b	c	d	e	f

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Weekday Sleep Schedule		
Write in the amount of time your child sleeps during a 24-hour period during weekdays: (Add daytime and nighttime sleep)		
The child's usual bedtime on weekdays nights:		
The child's usual wake time on weekday mornings:		
Weekend/Vacation Sleep Schedule		
Write in the amount of time your child sleeps during a 24-hour period during weekends and vacations: (Add daytime and nighttime sleep)		
The child's usual bedtime on weekend and vacation nights:		
The child's usual wake time on weekend and vacation mornings:		
Nap Schedule		
Number of days each week child takes a nap:	0 1 2 3 4 5 6 7	
If child naps, write in usual nap time(s):	Nap 1:__________am/pm to __________am/pm Nap 2:__________am/pm to __________am/pm	
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 a parent present when your child falls asleep?	Yes	No
Child usually falls asleep in:	○ Own room in own bed (alone) ○ Parents' room in own bed ○ Parents' room in parents' bed ○ Sibling's room in own bed ○ Sibling's room in sibling's bed	
Child sleeps most of the night in:	○ Own room in own bed (alone) ○ Parents' room in own bed ○ Parents' room in parents' bed ○ Sibling's room in own bed ○ Sibling's room in sibling's bed	
Child usually wakes in the morning in:	○ Own room in own bed (alone) ○ Parents' room in own bed ○ Parents' room in parents' bed ○ Sibling's room in own bed ○ Sibling's room in sibling's bed	
Child is usually put to bed by:	○ Mother ○ Father ○ Both Parents	○ Self ○ Others
Write 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 at night?	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 poor sleeper?	Yes	No	If ***yes***, do you think this is a problem?	Yes	No

Current Sleep Symptoms

(a) Never-does not happen
(b) Not often (less than 1 day 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

Please circle one:

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	Sleep-talking	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-crawling feeling)	a	b	c	d	e	f
19	Wets bed	a	b	c	d	e	f

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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?					
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 grades this year:	Excellent	Good	Average	Poor	Failing
Child's grade last year:	Excellent	Good	Average	Poor	Failing

Family Information

Does anyone in the family have a sleep disorder?	Yes		No	
If **yes**, mark the disorder(s):				
Insomnia	○ Mother	○ Father	○ Sibling	○ Grandparent
Snoring	○ Mother	○ Father	○ Sibling	○ Grandparent
Sleep apnea	○ Mother	○ Father	○ Sibling	○ Grandparent
Restless lets syndrome	○ Mother	○ Father	○ Sibling	○ Grandparent
Periodic limb movement disorder	○ Mother	○ Father	○ Sibling	○ Grandparent
Sleepwalking/sleep terrors	○ Mother	○ Father	○ Sibling	○ Grandparent
Sleep talking	○ Mother	○ Father	○ Sibling	○ Grandparent
Narcolepsy	○ Mother	○ Father	○ Sibling	○ Grandparent
Other:	○ Mother	○ Father	○ Sibling	○ Grandparent