Children's Mercy HOSPITALS & CLINICS

Sleep Clinic
Caregiver Questionnaire

7030-005 MR 03/13

Patient Name: _____ Date of Birth: ____/____/____

Referring Physician: _____ Office Phone Number: (____)_____-_____

Address: _____
Street City State Zip

What are your main sleep concerns? _____

_____

_____

Has your child had a previous sleep evaluation? ☐ No ☐ Yes (see below)

Name of Hospital or Sleep Center: _____

Address: _____
Street City State Zip

Has your child had a sleep study? ☐ No ☐ Yes, approximate date: _____

Current Medications (including prescribed, over-the-counter, herbal preparations, and dietary supplements): ☐ None

_____

_____

_____

Past Medical History

1. Was the child born prematurely? ☐ No ☐ Yes, how many weeks early? _____
   If yes, were there complications? ☐ No ☐ Yes, explain: _____
2. Has the child's weight changed in the last 6 months? ☐ No ☐ Yes, gained _____ pounds ☐ Yes, lost _____ pounds
3. Has the child had his/her tonsils removed? ☐ No ☐ Yes, at what age? _____
4. Has the child ever had surgery? ☐ No ☐ Yes, what kind and at what age? _____
5. Does the child have any medical problems? ☐ No ☐ Yes, describe: _____

   _____

   _____
6. Has the child ever had to stay in the hospital? ☐ No ☐ Yes, why? _____

   _____

Family History

Have the child's *blood* relatives (parents, grandparents, aunts, uncles, brothers, sisters), living or deceased, had a sleep disorder? Check all that apply.

☐ No ☐ Obstructive sleep apnea ☐ Narcolepsy ☐ Restless leg syndrome (RLS) ☐ Periodic limb movement (PLM)

☐ Other (describe): _____

_____ _____
Signature of Person Completing This Form Printed Name of Person Completing This Form

_____ ____/____/____ _____ hours
Relationship to Child Date Time

STAFF USE ONLY

Social History: _____

_____

Review of Systems

☐ General: _____ ☐ Skin: _____
☐ Eyes: _____ ☐ Musculoskeletal: _____
☐ ENT: _____ ☐ Neurological: _____
☐ Respiratory: _____ ☐ Behavioral/Mental Status: _____
☐ Cardiovascular: _____ ☐ Hematologic/Lymphatic: _____
☐ Gastrointestinal: _____ ☐ Allergic/Immunologic: _____
☐ Genitourinary: _____ ☐ Endocrine/Growth: _____

☐ See review of systems dated ____/____/____ ☐ Reviewed with patient/family. ☐ All Other Systems Negative

Reviewed By: _____ _____ ____/____/____ _____ hours
Signature Title Date Time

Children's Mercy HOSPITALS & CLINICS

Infant and Toddler Sleep Habits Questionnaire (Front)

7030-006 MR 03/13

Patient Name: _____ Date of Birth: ____/____/____

Thinking about your child's sleep over the **past 2 weeks**, answer the following questions.

1. **Which of the following does your child sleep in most of the time?**

   ☐ Crib ☐ Bassinet ☐ Own bed (any size) ☐ Infant seat ☐ Parents' bed (any size) ☐ Swing

   ☐ Other, specify: _____

2. **In what position does your child sleep most of the time?**

   ☐ On his/her belly ☐ On his/her side ☐ On his/her back

3. **Which of the following usually occur on most nights for your child in the hour before bedtime? (Check all that apply.)**

   ☐ Bath ☐ Reading books or being read to ☐ Watching television ☐ Being rocked ☐ Saying prayers

   ☐ Massage ☐ Having a bottle or drink, or nursing ☐ Running around ☐ Brushing teeth ☐ Cuddling

   ☐ Playing ☐ Having dinner or a snack ☐ Listening to music ☐ Singing songs

   ☐ Other, specify: _____

4. **How does your child fall asleep most of the time? (Check all that apply.)**

   ☐ While being held ☐ While being breastfed/nursing ☐ In his/her own crib or bed alone in the room

   ☐ While being bottle fed ☐ While watching television ☐ In his/her own crib or bed with a parent in the room

   ☐ While being rocked ☐ In parents' bed alone in the room ☐ In another room of the house (such as living room)

   ☐ In swing or stroller ☐ In parents' bed with a parent in the room

   ☐ Other, specify: _____

5. **In a typical 7-day week, how often does your child have the exact same bedtime routine?**

   ☐ Never ☐ 1-2 nights per week ☐ 3-4 nights per week ☐ 5-6 nights per week ☐ Every night

6. **What time do you usually start your child's bedtime routine?** _____

7. **What time do you usually put your child to bed at night (time of turning out the light)?** _____

8. **Typically, how difficult is bedtime for your child (for example, fussing, crying, protesting)?**

   ☐ Very easy ☐ Somewhat easy ☐ Neither easy nor difficult ☐ Somewhat difficult ☐ Very difficult

9. **How long does it typically take your child to fall asleep?** (EXAMPLE: If you put your child to bed at 9:00 pm, and your child falls asleep at 9:15 pm, it took 15 minutes for your child to fall asleep.)

   ☐ Less than 5 minutes ☐ 5-15 minutes ☐ 16-30 minutes ☐ 31-60 minutes ☐ More than 1 hour

10. **How often, if ever, does your child have a difficult time falling asleep?**

    ☐ Every night ☐ 5-6 nights per week ☐ 3-4 nights per week ☐ 1-2 nights per week

    ☐ 1-3 nights per month ☐ Less than once a month ☐ Never

11. **How many times does your child typically wake during the night?** _____

12. **How often does your child wake during the night, if ever?**

    ☐ Every night ☐ 5-6 nights per week ☐ 3-4 nights per week ☐ 1-2 nights per week

    ☐ 1-3 nights per month ☐ Less than once a month ☐ Never

Children's Mercy HOSPITALS & CLINICS

Infant and Toddler Sleep Habits Questionnaire (Back)

7030-006 MR 03/13

13. **When your child wakes up during the night, what do you do? (Check all that apply.)**

- ☐ Pick up my child and hold/rock him or her until the child falls asleep.
- ☐ Pick up my child and put him/her back down while the child is still awake.
- ☐ Let my child cry and fall back to sleep by himself/herself.
- ☐ Give my child a few minutes to see if he/she falls back to sleep.
- ☐ Play with my child until he/she is ready to go back to sleep.
- ☐ Watch television or a video with my child until he/she falls asleep.
- ☐ Bottle-feed my child back to sleep.
- ☐ Breastfeed/nurse my child back to sleep.
- ☐ Give my child a pacifier.
- ☐ Change my child's diaper.
- ☐ Bring my child into my bed.
- ☐ Sing to my child.
- ☐ Rub or pat my child, but do not pick him/her up or take him/her out of the crib or bed.
- ☐ Comfort my child verbally, but do not pick up the child or take him/her out of the crib or bed.
- ☐ Other, specify:_____

14. **On a typical night, how much total time during the NIGHT is your child awake?** (EXAMPLE: If your child woke up two times, and was awake for about 15 minutes each time, your child's total time spent awake would be 30 minutes.)

_____ hours _____ minutes

15. **On a typical night, what is the longest stretch of time that your child is asleep during the night without waking up?**

_____ hours _____ minutes

16. **How much total time does your child spend in sleep during the NIGHT** (between 7:00 pm and 8:00 am)?

_____ hours _____ minutes

17. **How many naps does your child take during a typical DAY** (between 8:00 am and 7:00 pm)? _____ hours _____ minutes

18. **How much time does your child spend in sleep during the DAY** (between 8:00 am and 7:00 pm)? _____ hours _____ minutes

19. **How well does your child sleep at night? (Check one.)**

☐ Very well ☐ Well ☐ Fairly well ☐ Fairly poorly ☐ Poorly ☐ Very poorly

20. **Do you consider your child sleep as a problem?** ☐ A very serious problem ☐ A small problem ☐ Not a problem at all

21. **Does your child do any of the following?**

	Never	Seldom	Occasionally	Often	Always
Snores	☐	☐	☐	☐	☐
Sleeps with mouth open and breathes loudly.	☐	☐	☐	☐	☐
Pauses breathing, or chokes/gasps.	☐	☐	☐	☐	☐
Sweats excessively during sleep.	☐	☐	☐	☐	☐
Kicks or twitches arms or legs during sleep.	☐	☐	☐	☐	☐
Tosses and turns during sleep.	☐	☐	☐	☐	☐
Wakes up screaming, unaware of surroundings.	☐	☐	☐	☐	☐

_____ Signature of Person Completing This Form

_____ Printed Name of Person Completing This Form

_____ Relationship to Child

_____/_____/_____ Date

_____ hours Time

STAFF USE ONLY

☐ Less than 9 hours total sleep time ☐ More than 1 hour total wake time at night ☐ More than 3 awakenings

Reviewed By: _____ Signature _____ Title _____/_____/_____ Date _____ hours Time