

Patient Name: _____

Date: _____

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."

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?	Y N DK	A6
HAVE YOU EVER seen your child stop breathing during the night?	Y N DK	A7
If so, please describe what has happened:		
... 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?	Y N DK	A11
DOES YOUR CHILD 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?	Y N DK	A13b
WHILE YOUR CHILD SLEEPS, HAVE YOU SEEN ...		
... 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)?	Y N DK	A14a
AT NIGHT, DOES YOUR CHILD USUALLY ...		
... 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?	Y N DK	A17
If so, how many times each night, on average?	_____ times	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?	Y N DK	A37
If so, please describe what has happened:		
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 <u>goes to bed</u> change a lot from day to day?	Y N DK	A47
Does the time at which your child <u>gets up from bed</u> change a lot from day to day?	Y N DK	A48
WHAT TIME DOES YOUR CHILD USUALLY ...		
... 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:		Office Use Only
DOES YOUR CHILD ...		
... wake up feeling <u>un</u> refreshed 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?	Y N DK	B9
If so, please describe what happened:		
Does your child still have tonsils?	Y N DK	B10
If not, when and why were they removed?:		
HAS YOUR CHILD EVER ...		
... had a condition causing difficulty with breathing?	Y N DK	B11

If so, please describe:		
... had surgery?	Y N DK	B12
If so, did any difficulties with breathing occur before, during, or after surgery?	Y N DK	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)?	Y N DK	B18
If so, how many cups or cans per day?	_____ cups	B18a
Does your child use any recreational drugs?	Y N DK	B19
If so, which ones and how often?:		
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?	Y N DK	B22
If so, at what age did this first develop?	_____ years	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

THANK YOU!

CHILD SLEEP HABITS
(Preschool and School-Aged)

Child's name: _____

The following statements are about your child's sleep habits and possible difficulties with sleep. Think about the **past week** in your child's life when answering the questions. If last week was unusual for a specific reason (such as your child had an ear infection and did not sleep well or the TV set was broken), choose the most recent typical week. Answer **USUALLY** if something occurs **5 or more times** in a week; answer **SOMETIMES** if it occurs **2-4 times** in a week; answer **RARELY** if something **occurs never or 1 time** during a week. Also, please indicate whether or not the sleep habit is a problem by circling "Yes," "No," or "Not Applicable" (N/A).

Bedtime Routine

Write in child's bedtime: _____

	3	2	1			
	Usually	Sometimes	Rarely	Problem?		
1. Child falls asleep in parent's bed or sibling's bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
2. Child struggles at bedtime (cries, refuses to stay in bed, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
3. Child needs parents in the room to fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
4. Child is afraid to sleep alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
5.* Child goes to bed at the same time at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
6.* Child falls asleep alone in own bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
(For clinical use only)	—	—	—	_____ (7)		

Nighttime Fears

	3	2	1			
	Usually	Sometimes	Rarely	Problem?		
7. Child is afraid of sleeping in the dark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
8. Child has trouble sleeping away from home, (visiting relatives, vacation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
(For clinical use only: (add # 7 and 8)	—	—	—	_____ (5)		

Waking During the Night

	3	2	1			
	Usually	Sometimes	Rarely	Problem?		
9. Child moves to someone else's bed during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
10. Child awakes once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
11. Child awakes more than once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
(For clinical use only)	—	—	—	_____ (3.5)		

Signature of Person Completing This Form:

Printed Name of Person Completing This Form

Relationship to Child

____/____/____
Date