

Pediatric Sleep Questionnaire

Child's name:	(Last)	(First)	(M.I.)
Name of person answering questions:			
Relation to child:			
Your phone number, days:	(Area code)	(Number)	, and evenings:
	(Area code)	(Number)	
Relative's name in case we cannot reach you:			
Relative's phone number:	(Area code)	(Number)	
Instructions			
<p>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 select the appropriate button. 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."</p>			
General information about your child			Office use only
Where are you completing this questionnaire?			G11
Today's date:	(Month)	(Day)	(Year)
Date of child's birth:	(Month)	(Day)	(Year)
Sex:	Male	Female	G14
Current height (feet/inches):			G15
Current weight (pounds):			G16
Grade in school (if applicable):			G17
Racial/Ethnic background of your child:			
American Indian	Asian American	African American	G18
Hispanic	White/not Hispanic	Other or unknown	G19

A. Nighttime and sleep behavior				Office use only
While sleeping does your child...	Y	N	DK	
... ever snore?				A1
... snore more than half the time?				A2
... always snore?				A3
... snore loudly?				A4
... have "heavy" or loud breathing?				A5
... have trouble breathing, or struggling to breathe?				A6
Have you ever...	Y	N	DK	
... seen your child stop breathing during the night?				A7
If so, please describe what has happened:				
... been concerned about your child's breathing during sleep?				A8
... had to shake your sleeping child to get him or her to breathe, or wake up and breathe?				A9
... seen your child wake up with a snorting sound?				A11
Does your child...	Y	N	DK	
... have restless sleep?				A12
... describe restlessness of the legs when in bed?				A13
... have "growing pains" (unexplained leg pains)?				A13a
... have "growing pains" that are worst in bed?				A13b
While your child sleeps, have you seen...	Y	N	DK	
... brief kicks of one leg or both legs?				A14
... repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)?				A14a
At night, does your child usually...	Y	N	DK	
... become sweaty, or do the pajamas usually become wet with perspiration?				A15
... get out of bed (for any reason)?				A16
... get out of bed to urinate?				A17
If so, how many times each night, on average?	(Number of times)			A17a

	Y	N	DK	
Does your child usually sleep with the mouth open?				A21
Is your child's nose usually congested or "stuffed" at night?				A22
Do any allergies affect your child's ability to breathe through the nose?				A23
Does your child...	Y	N	DK	
... tend to breathe through the mouth during the day?				A24
... have a dry mouth on waking up in the morning?				A25
... complain of an upset stomach at night?				A27
... get a burning feeling in the throat at night?				A29
... grind his or her teeth at night?				A30
... occasionally wet the bed?				A32
Has your child ever walked during sleep ("sleep walking")?				A33
Have you ever heard your child talk during sleep ("sleep talking")?				A34
Does your child have nightmares once a week or more on average?				A35
Has your child ever woken up screaming during the night?				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?				A37
If so, please describe what has happened:				
Does your child have difficulty falling asleep at night?				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?				A42
Does your child...	Y	N	DK	
... bang his or her head or rock his or her body when going to sleep?				A43
... wake up more than twice a night on average?				A44
... have trouble falling back asleep if he or she wakes up at night?				A45
... wake up early in the morning and have difficulty going back to sleep?				A46
Does the time at which your child <u>goes to bed</u> change a lot from day to day?				A47
Does the time at which your child <u>gets up from bed</u> change a lot from day to day?				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 weekend or vacation 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...	Y	N	DK	
... wake up feeling unrefreshed in the morning?				B1
... have a problem with sleepiness during the day?				B2
... complain that he or she feels sleepy during the day?				B3
Has a teacher or other supervisor commented that your child appears sleepy during the day?				B4
Does your child usually take a nap during the day?				B5
Is it hard to wake your child up in the morning?				B6
Does your child wake up with headaches in the morning?				B7
Does your child get a headache at least once a month, on average?				B8
Did your child stop growing at a normal rate at any time since birth?				B9
If so, please describe what happened:				
Does your child still have tonsils?				B10
If not, when and why were they removed?:				
Has your child ever...	Y	N	DK	
... had a condition causing difficulty with breathing?				B11
If so, please describe:				

	Y	N	DK	
... had surgery?				B12
If so, did any difficulties with breathing occur before, during, or after surgery?				B12a
... become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?				B13
... felt unable to move for a short period, in bed, though awake and able to look around?				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?				B16
Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?				B17
Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)?				B18
If so, how many cups or cans per day?	(Cups)			B18a
Does your child use any recreational drugs?				B19
If so, which ones and how often?				
Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products?				B20
If so, which ones and how often?				
Is your child overweight?				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)?				B23
Has your child ever taken Ritalin (methylphenidate) for behavioral problems?				B24
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?				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

Medicine	Size (mg) or amount per dose	Taken when?

Effect

Medicine	Size (mg) or amount per dose	Taken when?

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

Medicine	Size (mg) or amount per dose	Taken how often?	Dates taken

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.

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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.

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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.

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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.

Adapted from: Chervin, R. D. (2019, September 1). | *Umich Flintbox*. Umich.flintbox.com. <https://umich.flintbox.com/technologies/99aff626-f4d9-4529-aa3a-a509ed8ec905>