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: ☐ Male ☐ Female	
Child's birthdate:		Child's age:	
Child's racial/ethnic background:	☐ White/Caucasian	☐ Black/African-American	☐ Asian-American
	☐ Native-American	☐ Hispanic-Latino	☐ Multi-racial
	☐ Other		

What are your major concerns about your child's sleep?
What things have you tried to help your child's problem?

SLEEP HISTORY

Weekday Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period on weekdays (add daytime and nighttime sleep): ______ hours ______ minutes

The child's usual bedtime on weekday nights : ______:______

The child's usual waketime on weekday mornings: ______:______

Weekend/Vacation Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period during weekends and vacations (add daytime and nighttime sleep): ______ hours ______ minutes

The child's usual bedtime on weekend/vacation nights : ______:______

The child's usual waketime on weekend/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: _____ : _____ ☐ a.m. ☐ p.m. to _____ : _____ ☐ a.m. ☐ p.m.

Nap 2: _____ : _____ ☐ a.m. ☐ p.m. to _____ : _____ ☐ a.m. ☐ p.m.

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...	Child sleeps most of the night in...	Child usually wakes in the morning in...
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ own room in own bed (alone)
☐ parents' room in own bed	☐ parents' room in own bed	☐ parents' room in own bed
☐ parents' room in parents' bed	☐ parents' room in parents' bed	☐ parents' room in parents' bed
☐ sibling's room in own bed	☐ sibling's room in own bed	☐ sibling's room in own bed
☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed

Child is usually put to bed by: ☐ Mother ☐ Father ☐ Both Parents ☐ Self ☐ Others

Write in 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?	☐ 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 a 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 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

		(a)	(b)	(c)	(d)	(e)	(f)
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.	Sleeptalking	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

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
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

Screening Questionnaire: Obstructive Sleep Apnea

Name: ____________________________________
Person completing form: _____________________ Date: ___/____/____

Please answer the following questions as they pertain to your child in the past month.

1. **While sleeping, does your child:**

Snore more than half the time? …………………..……………..……	Y	N	DK
Always snore? ………………………………….……………..……	Y	N	DK
Snore loudly? ……………………………….……………..……	Y	N	DK
Have "heavy" or loud breathing? …………………..…………….……	Y	N	DK
Have trouble breathing, or struggle to breathe? …………………….	Y	N	DK

2. **Have you ever seen your child stop breathing during the night?** ……………………………………...……………..…… Y N DK

3. **Does your child:**

Tend to breathe through the mouth during the day?…………………	Y	N	DK
Have a dry mouth on waking up in the morning?……………………	Y	N	DK
Occasionally wet the bed?……………………………..……………	Y	N	DK

4. **Does your child:**

Wake up feeling unrefreshed in the morning?………….……………	Y	N	DK
Have a problem with sleepiness during the day? ……………………	Y	N	DK

5. **Has a teacher or other supervisor commented that your child appears sleepy during the day?** ……………………………….. Y N DK

6. **Is it hard to wake your child up in the morning?** ……………….. Y N DK

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From: Mindell JA & Owens JA (2003). *A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems.* Philadelphia: Lippincott Williams & Wilkins.

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7. Does your child wake up with headaches in the morning? ………..	Y	N	DK
8. Did your child stop growing at a normal rate at any time since birth? ………………………..……………………..….	Y	N	DK
9. Is your child overweight? ………………………………………...	Y	N	DK
10. This child *often*:			
Does not seem to listen when spoken to directly ……………………	Y	N	DK
Has difficulty organizing tasks and activities ……………………	Y	N	DK
Is easily distracted by extraneous stimuli ……………………	Y	N	DK
Fidgets with hands or feet or squirms in seat ……………………	Y	N	DK
Does not seem to listen when spoken to directly ……………………	Y	N	DK
Is "on the go" or often acts as if "driven by a motor" ………..……	Y	N	DK
Interrupts or intrudes on others (eg., butts into conversations or games).	Y	N	DK

Scoring

Yes = 1
No = 0

Average all scores to obtain a score between 0.00 and 1.00. Preliminary analyses suggest a cut-off of >0.33 for abnormal.

(*For more information see Chervin RD, Hedger K, Dillon JE, Pituch KJ (2000). Pediatric Sleep Questionnaire (PSQ): validity and reliability of scales for sleep-disordered breathing, snoring, sleepiness, and behavioral problems. Sleep Medicine1:21-32.)*

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