embrace HEALTH™
SANTIAM HOSPITAL

Pediatric Sleep Evaluation Questionnaire

Child's Information	
Child's Name:	Child's Gender: ☐ Male ☐ Female
Child's Birth date:	Child's Age:
(	Today's Date:
Child's Primary Doctor:	Child's Referring Doctor:

Child's Problem or Area of Concern
What are your major concerns about your child's sleep?
What things have you done to help your child's problem?

Referral
Who asked that your child be seen by a sleep specialist?
☐ Pediatrician / Family Physician
☐ Child's parent or Guardian
☐ Surgical Specialist (e.g., ENT)
☐ Pediatric Specialist (e.g., allergist, neurologist, pulmonologist)
☐ Mental Health Worker (e.g., psychiatrist, psychologist, social worker)
☐ School teacher, nurse, counselor
☐ Child himself / herself
☐ Other:

Sleep History

Weekday Sleep Schedule

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

Child's usual bedtime on weekday nights: _____ : _____

Child's usual wake time on weekday mornings: _____ : _____

Weekend / Vacation Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekends or vacation days. (add daytime and nighttime sleep) _____ hours _____ minutes

Child's usual bedtime on weekday nights: _____ : _____

Child's usual wake time on weekday mornings: _____ : _____

Nap Schedule

Number of days each week the child takes a nap: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

If the child naps write in the 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 bed?	☐ Yes	☐ No
Does the child have his / her own bedroom?	☐ Yes	☐ No
Is a parent / guardian present when the child falls asleep?	☐ Yes	☐ No
Does the child listen / watch radio / TV in bed?	☐ Yes	☐ No

Child usually falls asleep in:	Child sleep most of the nightr 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)
☐ parent's room in own bed	☐ parent's room in own bed	☐ parent's room in own bed
☐ parent's room in parent's bed	☐ parent's room in parent's bed	☐ parent's room in parent's 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 in bed by: ☐ Mother ☐ Father ☐ Both parents ☐ Sibling ☐ Self ☐ Others

Write the amount of time the child spends I 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 a night time awakening, child has difficulty going back asleep?	☐ Yes	☐ No	IF yes, do you think this is a problem?	☐ Yes	☐	No
Child is difficult to wake 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					
1	Stops breathing during sleep	A	B	C	D	E	F
2	Has difficulty breathing when asleep	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	Has Nightmares	A	B	C	D	E	F
9	Sleep walks	A	B	C	D	E	F
10	Sleep talks	A	B	C	D	E	F
11	Screams out in his / her sleep	A	B	C	D	E	F
12	Kicks legs is sleep	A	B	C	D	E	F
13	Wakes up during the night	A	B	C	D	E	F
14	Gets out of bed at night	A	B	C	D	E	F
15	Trouble staying is his / her own 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 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 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					
1	Has trouble getting up in the morning	A	B	C	D	E	F
2	Falls asleep at school	A	B	C	D	E	F
3	Naps after school	A	B	C	D	E	F
4	Has daytime sleepiness	A	B	C	D	E	F
5	Feels weak or loses muscles control with strong emotions	A	B	C	D	E	F
6	Reports unable to move when falling asleep or awakening	A	B	C	D	E	F
7	Sees frighting images when falling asleep or awakening	A	B	C	D	E	F

Current Medical History

Please list any medications child is currently taking:

	Medication	Dose	How Often
1			
2			
3			
4			
5			

Long-Term Medical Problems

If the child has long-term medical problems, please list the three you think are the most important.

1 _____

2 _____

3 _____

Surgeries / Hospitalizations

Has the child had his / her tonsils removed? ☐ Yes Age of surgery: _____

Has the child has his her adenoids removed? ☐ Yes Age of surgery: _____

Has the child ever had ear tubes? ☐ Yes Age of surgery: _____

Please list any aditional hospitalizations or surgeries:

1 _____ Age: _____

2 _____ Age: _____

3 _____ Age: _____

Health Habits

Does the child drink caffeinated beverages? (e.g., Coke Pepsi, Mountian Dew, Orange Soda, Tea, coffee) ☐ No ☐ Yes Amount per day: _____ Time of last drink: _____

School Preformance (if school age)

Child's grade: _____

Has child ever repeated a grade? ☐ No ☐ Yes

Is child enrolled in any special education classes? ☐ No ☐ Yes

How many schol days has child missed this year? _____

How many school days did child miss last year? _____

How many school days has child been late this year? _____

How many school days was child late last year? _____

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Family Information

Pregnancy / Delivery

Pregnancy ☐ Normal ☐ Difficult

Delivery ☐ Term ☐ Pre-term ☐ Post-term

Child's Birth Weigth:

Only child? ☐ Yes ☐ No If No, circle birth order: 1st 2nd 3rd 4th 5th 6th

Mother

Age:

Marital Status: ☐ Married ☐ Divoriced ☐ Single ☐ Widowed ☐ Separated ☐ Remarried

Education:

Work: ☐ Unemployed ☐ Part-time ☐ Full-time

Occupation:

Father

Age:

Marital Status: ☐ Married ☐ Divoriced ☐ Single ☐ Widowed ☐ Separated ☐ Remarried

Education:

Work. ☐ Unemployed ☐ Part-time ☐ Full-time

Occupation:

Persons Living In Home

Name:	Relationship	Age:

Family Sleep History

Does anyone in the child's family have a sleep disorder? ☐ No ☐ Yes

If Yes, mark the disorders and relationship.

Insomnia	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Sleep Apnea	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Restless Legs Syndrome	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Periodic Limb Movement Disorder	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Sleep walking / sleep terrors	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother / sister	☐ Grandparent

Is there any other information you think would be helpful for the Physician to know?

Medical and Psychiatric History

Past Medical History

Frequent Nasal congestion	☐ Yes	Age of diagnosis.
Trouble breathing through nose	☐ Yes	Age of diagnosis.
Sinus problems	☐ Yes	Age of diagnosis.
Chronic bronchitis or cough	☐ Yes	Age of diagnosis.
Allergies	☐ Yes	Age of diagnosis.
Asthma	☐ Yes	Age of diagnosis.
Frequent Colds or Flu	☐ Yes	Age of diagnosis.
Frequent ear infections	☐ Yes	Age of diagnosis.
Frequent Strep throat infections	☐ Yes	Age of diagnosis.
Difficulty swallowing	☐ Yes	Age of diagnosis.
Acid reflux (gastroesophageal reflux)	☐ Yes	Age of diagnosis.
Poor or delayed growth	☐ Yes	Age of diagnosis.
Excessive weight	☐ Yes	Age of diagnosis.
Hearing problems	☐ Yes	Age of diagnosis.
Speech problems	☐ Yes	Age of diagnosis.
Vision problems	☐ Yes	Age of diagnosis.
Seizures / Epilepsy	☐ Yes	Age of diagnosis.
Morning headaches	☐ Yes	Age of diagnosis.
Cerebral palsy	☐ Yes	Age of diagnosis.
Heart disease	☐ Yes	Age of diagnosis.
High blood pressure	☐ Yes	Age of diagnosis.
Sickle cell disease	☐ Yes	Age of diagnosis.
Genetic disease	☐ Yes	Age of diagnosis.
Chromosome problem (e.g., Down's)	☐ Yes	Age of diagnosis.
Skeleton problem (e.g., dwarfism)	☐ Yes	Age of diagnosis.
Cranofacial disorder (e.g., Pierre-Robin)	☐ Yes	Age of diagnosis.
Thyroid problems	☐ Yes	Age of diagnosis.
Eczema (e.g., itchy skin)	☐ Yes	Age of diagnosis.
Pain	☐ Yes	Age of diagnosis.
Head / brain injury	☐ Yes	Age of diagnosis.
Meningitis	☐ Yes	Age of diagnosis.

Past Psychiatric / Psychological History

Autism	☐ Yes	Age of diagnosis.
Developmental Delay	☐ Yes	Age of diagnosis.
Hyperactivity / ADHD	☐ Yes	Age of diagnosis.
Anxiety / Panic attacks	☐ Yes	Age of diagnosis.
Obsessive Compulsive disorder	☐ Yes	Age of diagnosis.
Depression	☐ Yes	Age of diagnosis.
Suicide	☐ Yes	Age of diagnosis.
Learning disability	☐ Yes	Age of diagnosis.
Drug use / abuse	☐ Yes	Age of diagnosis.
Behavioral disorder	☐ Yes	Age of diagnosis.
Psychiatric admission	☐ Yes	Age of diagnosis.

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician or psychologist. _____

TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't got back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C M				
week 1																										
week 2																										