CHILDRENS SLEEP CENTER

PEDIATRIC SLEEP DISORDERS QUESTIONNAIRE (AGES 0-5)

Today's date: ______________________

Date of birth: ______________________ Social Security No.: ______________________

Name: ____

Address: ____
Street

____
City State Zip Code

Home #: ______________________ Parent/Guardian Work #: ______________________

Sex: __________ Height: __________ Weight: __________

Was patient (circle one): Full Term Premature

If patient was premature, please indicate gestational age at birth: ______________________

Referring Physician: ____

Address: ____

Telephone: ____

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Please let us know if your child has any special needs for the night of the sleep study (such as need for oxygen, if child is wheel-chair bound, requires IV pole, etc.). We will make every effort necessary to meet your child's needs and to make your stay with them as comfortable as possible.

Briefly describe your child's sleep problem:

What makes it better or worse?

How long has this been a problem?

How serious do you believe this problem is (circle one):

Very serious　　Somewhat serious　　Not at all serious

Has your child ever had a prior sleep study?

If yes, please describe the evaluation, treatment received and results:

How does the amount of sleep your child gets compare with others of the same age? (circle one)

More sleep　　About the same amount　　Less Sleep　　Not sure

What type of bedding does your child sleep on?

Crib　　Mattress　　Waterbed　　Chair　　Other ____________

Do others sleep in the same room with your child? ____________________

Do others sleep in the same bed with your child? ____________________

Does your child sleep better out of bed (for example, on the couch or floor)? ____________

____

Is your child breast or bottle-fed during the night? Yes No

If yes, how often? ____

Does your child sleep with a pacifier or bottle? Yes No

	Week Nights	Weekends
What is your child's normal bedtime?	________	________
How long does it normally take him/her to get to sleep?	________	________
How many times does he/she awaken during the night?	________	________

What wakes him/her up (if known)? ______________________________

How long does it take him/her to go back to sleep after awakening?	________	________
What time does he/she normally awaken?	________	________

Does he/she awaken spontaneously, by parent, or other? ______________________________

Does he/she stay in bed after awakening in the morning (yes or no)?	________	________
If so, when does he/she get out of bed?	________	________
If child attends daycare or preschool, what is their normal start time?	________	________

How does your child seem in the morning?

Alert and rested Sluggish Very groggy

How long does it take him/her to "get going" in the morning?

Few minutes 30 minutes An hour or more

Does your child complain of any aches or pains on waking? No Yes

If yes, describe: ____

How does your child behave during the day?

What is his/her best time of day (when most alert)? ____________________________

What is his/her worst time of day (when the most sleepy or demonstrates behavioral problems)?

____

How frequently does he/she take naps? Describe the time of day and length of the naps:

____

____

How does he/she behave after taking a nap (circle one)?

Very refreshed   Somewhat refreshed   Somewhat tired   Very drowsy

Does your child snore (circle one)?   No   Yes

Have you ever noticed periods during sleep when your child appears to stop breathing? _______

Is he/she a very active sleeper (example, awaken to find the sheets in disarray)?

Does he/she sweat excessively during the night?   No   Yes

Has your child ever experienced loss of muscle strength (weakness in knees, sagging facial muscles or total collapse) when excited, startled, angry or laughing?

No   Yes   Don't know/too young to express

Has your child ever expressed feelings of being unable to move when going to sleep or waking up?

No   Yes   Don't know/too young to express

Has your child ever mentioned seeing or hearing things that aren't real when going to sleep or waking up?

No   Yes   Don't know/too young to express

Do any of your family members have any of the three symptoms listed in the last three questions?

No   Yes   Don't know

Does your child complain of unpleasant sensations in his/her legs?

No   Yes   Don't know/too young to express

If yes, describe them and what you do to relieve them: ______________________________

____

____

Have you noticed your child kicking in his/her sleep?   No   Yes

CHECK ANY OF THE FOLLOWING YOU HAVE NOTICED OR YOUR CHILD HAS MENTIONED:

______Sleeping conditions too light
______Sleeping conditions too noisy
______Sleeping conditions too cool
______Change in appetite
______Change in energy level
______Change in concentration
______Increased tearfulness
______Decreased interests or motivation
______Decreased self-esteem
______Impulsive behavior
______Impulsive behavior
______Increased aggressiveness
______Irritable moods
______Thoughts of hurting others
______Trembling
______Dizziness or lightheadedness
______Dry mouth
______Numbness or tingling
______Feeling a "lump in throat"
______Increased heart rate
______Other (please describe):

______Sleeping conditions too dark
______Sleeping conditions too quiet
______Sleeping conditions too warm
______Stomach "tied in knots"
______Nausea or vomiting
______Increased urination (unusual for age)
______Muscle twitching or cramps
______Muscle tension
______Worrying constantly
______Checking and rechecking things
______Being a perfectionist
______Unwanted thoughts
______Rituals you MUST perform
______Superstitious thoughts
______Fear of germs
______Concerns about weight
______Concerns about appearance
______Skipping meals to lose weight
______Excessive eating
______Shortness of breath

____

____

____

How likely is your child to doze off or fall asleep in the following situations? Using the following numbers, place the most appropriate response in the space.

0 = Would never fall asleep
1= Slight chance of falling sleep
2= Moderate chance of falling asleep
3= High chance of falling asleep

______Sitting and reading
______Watching TV or video
______While being read to
______After meals
______Sitting quietly/playing

HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING DURING THEIR SLEEP (if age appropriate):

	Times per week	Age began	Last occurrence	Treatment (if any)
Talking	______	______	______	______
Sleepwalking	______	______	______	______
Grinding teeth	______	______	______	______
Bedwetting	______	______	______	______
Recurrent dreams	______	______	______	______
Disturbing dreams	______	______	______	______
Awakens screaming (during first three hours of the night):	______	______	______	______
Complains of chest pain, wheezing, rapid or irregular heart beat:	______	______	______	______
Waking up complaining of acid or sour taste in mouth:	______	______	______	______
Unusual movements during sleep:	______	______	______	______
Awakening with headaches or perspiration:				

______ ______ ______ ______

MEDICAL HISTORY

Date of last physical examination: ____________________

Is your child generally in good health as far as you know? ____________________

Has his/her weight changed in the last year (other than age/growth appropriate)? ________

If yes, how many pounds has he/she: **Gained** ______
Lost ______

List the current medication (prescribed or over the counter) you child currently takes:

____

____

List any allergies (medication or other): ____________________

____

Indicate the amount and times your child consumes caffeinated beverages: ____________

____

Indicate the types of medical problems your child has had or currently has:

Respiratory (asthma, etc) ______
Psychological ______
Diagnosed ADD/ADHD ______
Ear, nose and throat ______
Heart, circulation ______
Stomach, digestive ______
Kidney, urological ______
Head, neck, back and
nervous system ______
Accidents, injuries ______
Surgeries ______
Other: ______

Please give a description of the items marked with the dates of treatment (if known): ________

____

____