



**PEDIATRIC 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.

Date: \_\_\_\_\_

**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  
 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): \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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/vacations (add daytime and nighttime sleep): \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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

If child naps, write in usual nap time(s): Nap1: \_\_\_\_\_ : \_\_\_\_\_  a.m.  p.m. to \_\_\_\_\_ : \_\_\_\_\_  a.m.  p.m.

Nap2: \_\_\_\_\_ : \_\_\_\_\_  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 the parent present when your child falls asleep?       yes     no

<b>Child usually falls asleep in</b>	<b>Child sleeps most of the night in</b>	<b>Child usually wakes in the morning in</b>
<input type="checkbox"/> own room in own bed (alone)	<input type="checkbox"/> own room in own bed (alone)	<input type="checkbox"/> own room in own bed (alone)
<input type="checkbox"/> parents' room in own bed	<input type="checkbox"/> parents' room in own bed	<input type="checkbox"/> parents' room in own bed
<input type="checkbox"/> parents' room in parents' bed	<input type="checkbox"/> parents' room in parents' bed	<input type="checkbox"/> parents' room in parents' bed
<input type="checkbox"/> sibling's room in own bed	<input type="checkbox"/> sibling's room in own bed	<input type="checkbox"/> sibling's room in own bed
<input type="checkbox"/> sibling's room in sibling's bed	<input type="checkbox"/> sibling's room in sibling's bed	<input type="checkbox"/> 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, (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)

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**

(b) = never, (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)

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

**Pregnancy/Delivery**

Pregnancy:  Normal  Difficult

Delivery  Term  Pre-term  Post-term

Child's birthweight: \_\_\_\_\_

Only child?  Yes  No If no, circle birth order: 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup> 6<sup>th</sup> 7<sup>th</sup>

## MEDICAL AND PSYCHIATRIC HISTORY

### PAST MEDICAL HISTORY

Frequent nasal congestion	<input type="checkbox"/> Yes	Age of diagnosis:	
Trouble breathing through his/her nose	<input type="checkbox"/> Yes	Age of diagnosis:	
Sinus problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Chronic bronchitis or cough	<input type="checkbox"/> Yes	Age of diagnosis:	
Allergies	<input type="checkbox"/> Yes	Age of diagnosis:	Allergic to what:
Asthma	<input type="checkbox"/> Yes	Age of diagnosis:	
Frequent colds or flus	<input type="checkbox"/> Yes	Age of diagnosis:	
Frequent ear infections	<input type="checkbox"/> Yes	Age of diagnosis:	
Frequent strep throat infections	<input type="checkbox"/> Yes	Age of diagnosis:	
Difficulty swallowing	<input type="checkbox"/> Yes	Age of diagnosis:	
Acid reflux (gastroesophageal reflux)	<input type="checkbox"/> Yes	Age of diagnosis:	
Poor or delayed growth	<input type="checkbox"/> Yes	Age of diagnosis:	
Excessive weight	<input type="checkbox"/> Yes	Age of diagnosis:	
Hearing problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Speech problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Vision problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Seizures/Epilepsy	<input type="checkbox"/> Yes	Age of diagnosis:	
Morning headaches	<input type="checkbox"/> Yes	Age of diagnosis:	
Cerebral palsy	<input type="checkbox"/> Yes	Age of diagnosis:	
Heart disease	<input type="checkbox"/> Yes	Age of diagnosis:	
High blood pressure	<input type="checkbox"/> Yes	Age of diagnosis:	
Sickle cell disease	<input type="checkbox"/> Yes	Age of diagnosis:	
Genetic disease	<input type="checkbox"/> Yes	Age of diagnosis:	
Chromosome problem (e.g., Down's)	<input type="checkbox"/> Yes	Age of diagnosis:	
Skeleton problem (e.g., dwarfism)	<input type="checkbox"/> Yes	Age of diagnosis:	
Craniofacial disorder (e.g., Pierre-Robin)	<input type="checkbox"/> Yes	Age of diagnosis:	
Thyroid problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Eczema (itchy skin)	<input type="checkbox"/> Yes	Age of diagnosis:	
Pain	<input type="checkbox"/> 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/psychologist. \_\_\_\_\_

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**CURRENT MEDICAL HISTORY**

Please list any medications your child currently takes:

Medicine	Dose	How often?

**LONG-TERM MEDICAL PROBLEMS**

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**SURGERIES/HOSPITALIZATIONS**

Has your child ever had his/her tonsils removed?  Yes  No Age of surgery: \_\_\_\_\_

Has our child ever had his/her adenoids removed?  Yes  No Age of surgery: \_\_\_\_\_

Has our child ever had ear tubes?  Yes  No Age of surgery: \_\_\_\_\_

Please list any additional hospitalizations or surgeries: \_\_\_\_\_

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**HEALTH HABITS**

Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)  Yes  No Amount per day: \_\_\_\_\_

**SCHOOL PERFORMANCE**

**CURRENT SCHOOL PERFORMANCE (if school-aged)**

Your child's grade: \_\_\_\_\_

Has your child ever repeated a grade?  Yes  No

Is your child enrolled in any special education class?  Yes  No

How many school days has your child missed so far this year? \_\_\_\_\_

How many school days did your child miss last year? \_\_\_\_\_

How many school days was your child last so far this year? \_\_\_\_\_

How many school days was your child last year? \_\_\_\_\_

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

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

## FAMILY'S INFORMATION

### MOTHER

### FATHER

Age: \_\_\_\_\_

Age: \_\_\_\_\_

Marital Status:    Single       Divorced       Separated  
                          Married       Widowed       Remarried

Single       Divorced       Separated  
 Married       Widowed       Remarried

Education: \_\_\_\_\_

Education: \_\_\_\_\_

Work:    Unemployed     Part-time     Full-time

Work:  Unemployed    Part-time    Full-time

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

### PERSONS LIVING IN HOME

**Name:**

**Relationship:**

**Age:**

Name:	Relationship:	Age:

### FAMILY SLEEP HISTORY

Does anyone in the family have a sleep disorder?     Yes                       No

If yes, mark the disorder(s):

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

Sleepwalking/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

## 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 specialist (e.g., psychiatrist, psychologist, social worker)
- School teach, nurse, counselor
- Child himself/herself
- Other: \_\_\_\_\_

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**SCREENING QUESTIONNAIRE:  
Obstructive Sleep Apnea**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relation: \_\_\_\_\_

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

1. While sleeping, does your child:
  - a. Snore more than half the time?  Yes  No  Unknown
  - b. Always snore?  Yes  No  Unknown
  - c. Snore loudly?  Yes  No  Unknown
  - d. Have "heavy" or loud breathing?  Yes  No  Unknown
2. Have you ever seen our child stop breathing during The night?  Yes  No  Unknown
3. Does your child:
  - a. Tend to breath through the mouth during the day?  Yes  No  Unknown
  - b. Have a dry mouth on waking up in the morning?  Yes  No  Unknown
  - c. Occasionally wet the bed?  Yes  No  Unknown
4. Does your child:
  - a. Wake up feeling unrefreshed in the morning?  Yes  No  Unknown
  - b. Have a problem with sleepiness during the day?  Yes  No  Unknown
5. Has a teacher or other supervisor commented that your Child appears sleepy during the day?  Yes  No  Unknown
6. Is it hard to wake your child up in the morning?  Yes  No  Unknown
7. Does your child wake up with headaches in the morning?  Yes  No  Unknown
8. Did your child stop growing at a normal rate at any time since birth?  Yes  No  Unknown

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9. Is your child overweight?  Yes  No  Unknown
10. This child *often*:
- a. Does not seem to listen when spoken to directly  Yes  No  Unknown
  - b. Has difficulty organizing tasks and activities  Yes  No  Unknown
  - c. Is easily distracted by extraneous stimuli  Yes  No  Unknown
  - d. Fidgets with hands or feet or squirms in seat  Yes  No  Unknown
  - e. Does not seem to listen when spoken to directly  Yes  No  Unknown
  - f. Is “on the go” or often acts as if “driven by a motor”  Yes  No  Unknown
  - g. Interrupts or intrudes on others (e.g., butts into conversations or games)  Yes  No  Unknown

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 Medicine 1:21-32.)*

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7. Does anyone in the family have severe problems falling or staying asleep?
- Yes    No      If so, who: \_\_\_\_\_
8. How often, on average, does your child consume caffeine-containing beverages or food? (coffee, tea, cola beverages, chocolate)
- Never    Occasionally (less than 1x/month)    sometimes (1-2x/month)    frequently (1-2x/wk to daily)
9. Has your child ever been diagnosed and/or treated for anemia?
- Yes    No    Unknown      If so, date, type of anemia, and treatment: \_\_\_\_\_

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