Children's MINNESOTA

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 child's sleep and daytime symptoms.

CHILD'S INFORMATION

Child's name:	Child's gender: ☐ Male ☐ Female
Child's Birth Date:	Child's Age:
Parent Name & Contact #:	
Patient Preferred Pharmacy:	

REFERRAL

Who asked that your child be seen by a sleep specialist?	Name	Phone Number
☐ Child's parent or guardian		
☐ Pediatrician/family physician	_____	_____
☐ Surgical specialist (e.g., ENT)	_____	_____
☐ Pediatric Specialist (e.g., allergist, neurologist, pulmonologist)	_____	_____
☐ Mental health specialist (e.g. psychiatrist, psychologist, social worker)	_____	_____
☐ School teacher, nurse, counselor		
☐ Child himself/herself		
☐ Other:	_____	_____

List 3 concerns about your child's sleep?

1. _____
2. _____
3. _____

How long has this been a concern: _____ months/years ☐ lifelong

What things have you tried to help your child's problem?

What help would you like from this visit?

* S L P D I S Q U E *

SLEEP HISTORY

WEEKDAY SLEEP SCHEDULE

- Your child's usual bedtime on week day nights: _____ : _____
- Time that child actually falls asleep _____ : _____
- Your child's usual wake time on week day mornings: _____ : _____ ☐ WAKES BY SELF ☐ BY PARENT

WEEKEND/VACATION SLEEP SCHEDULE

- Your child's usual bedtime on weekend nights: _____ : _____
- Time that child actually falls asleep _____ : _____
- Your child's usual wake time on weekend mornings: _____ : _____ ☐ WAKES BY SELF ☐ BY PARENT

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.

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

☐ At daycare

GENERAL SLEEP

- Does the child have a regular bedtime routine? ☐ YES ☐ NO BRIEFLY DESCRIBE:
- Is it a pleasant experience? ☐ YES ☐ NO
- How long before "lights out" does it begin? _____ minutes
- Does the child have his/her own bedroom? ☐ YES ☐ NO
- Does the child have his/her own bed? ☐ YES ☐ NO

Type of bed ☐ CRIB ☐ SINGLE BED ☐ DOUBLE BED ☐ OTHER

Is a parent present when your child falls asleep? ☐ yes ☐ no

Child usually falls asleep in:	Child usually wakes in the morning in:	Child is usually put to bed by:
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ Mother
☐ parent's room in own bed	☐ parent's room in own bed	☐ Father
☐ parent's room in parent's bed	☐ parent's room in parent's bed	☐ Both Parents
☐ sibilng's room in own bed	☐ sibilng's room in own bed	☐ Self
☐ siblings room in sibling's bed	☐ siblings room in sibling's bed	☐ Others _____
☐ Other: _____	☐ Other: _____	

How long does it take him/her to fall asleep: _____ minutes/hours

Write in the amount of time the child spends in his/her bedroom before going to sleep: _____ minutes/hours
In the last two weeks, what was the quickest time it has taken your child to fall asleep? _____ minutes/hours
What was the longest time? _____ minutes/hours

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
			And for how long? _____ minutes/hours		

BEDROOM ENVIRONMENT

Night Light	☐ YES	☐ NO	How long before lights out are electronics turned off:
Sound Machine/White Noise	☐ YES	☐ NO	☐ THEY ARE NOT
TV	☐ YES	☐ NO	☐ KEPT ON WHILE SLEEPING
Computer/Smart Pad	☐ YES	☐ NO	☐ 15 MINUTES
Video Game Device	☐ YES	☐ NO	☐ 30 MINUTES
Text/Smart Phone	☐ YES	☐ NO	☐ 60 MINUTES
Pets in bed with child while sleeping	☐ YES	☐ NO	☐ _____
Fish Tank	☐ YES	☐ NO	

CURRENT SLEEP SYMPTOMS							
							(f) do not know
						(e) always (6 to 7 nights/days a week)	
					(d) often (3 to 5 nights/days a week)		
				(c) sometimes (1 to 2 nights/days a week)			
			(b) not often (less than 1 night/day a week)				
		(a) never (does not happen)					
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.	Gasping/choking	a	b	c	d	e	f
5.	Mouth breathing while asleep	a	b	c	d	e	f
6.	Dry mouth during the night or in the morning	a	b	c	d	e	f
7.	Poor appetite	a	b	c	d	e	f
8.	Sweating when sleeping	a	b	c	d	e	f
9.	Nightmares	a	b	c	d	e	f
10.	Sleepwalking	a	b	c	d	e	f
11.	Sleeptalking	a	b	c	d	e	f
12.	Screaming in his/her sleep	a	b	c	d	e	f
13.	Restless sleep	a	b	c	d	e	f
14.	Kicks legs in sleep	a	b	c	d	e	f
15.	Wakes up at night	a	b	c	d	e	f
16.	Gets out of bed at night	a	b	c	d	e	f
17.	Trouble staying in his/her bed	a	b	c	d	e	f
18.	Resists going to bed at bedtime	a	b	c	d	e	f
19.	Grinds his/her teeth	a	b	c	d	e	f
20.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
21.	Wets bed (over age 5)	a	b	c	d	e	f

After nighttime awakening, child has difficulty falling back to sleep? **If yes,** do you think this is a problem?	☐ yes ☐ no ☐ yes ☐ no
Child is difficult to awaken in the morning? **If yes,** do you think this is a problem?	☐ yes ☐ no ☐ yes ☐ no
Child is a poor sleeper? **If yes,** do you think this is a problem?	☐ yes ☐ no ☐ yes ☐ no
Has your child often seemed to get more or less sleep than other children their age?	☐ yes ☐ no
Does child have an overactive mind?	☐ yes ☐ no
Does child sleep better away from home?	☐ yes ☐ no
Is child a "clock watcher"?	☐ yes ☐ no
Estimate how many hours of actual sleep child is obtaining in a typical 24 hour period during the week:	_____
Estimate how many hours of actual sleep child is obtaining on a typical weekend/vacation:	_____

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.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
2.5	Falls asleep on the way to or from 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 (laughter, anger, etc.)	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

Additional comments about daytime symptoms:

PREGNANCY/DELIVERY

Pregnancy	☐ Normal	☐ Difficult
Delivery	☐ Normal	☐ Difficult
Child's Birthweight:		☐ Full Term ☐ Premature: _____ weeks
Only child?	☐ Yes	☐ No If no, circle birth order: 1st 2nd 3rd 4th 5th 6th 7th

SLEEPINESS SCALE

How likely is your child to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to think how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Probability of Dozing**			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Sitting quietly after a meal	0	1	2	3

PHYSICAL AND MENTAL HEALTH			
PAST MEDICAL HISTORY			**DETAILS**
Frequent nasal congestion	☐ Yes	Age of diagnosis:	
Trouble breathing through his/her nose	☐ Yes	Age of diagnosis:	
Sinus problems	☐ Yes	Age of diagnosis:	
Chronic bronchitis or cough	☐ Yes	Age of diagnosis:	
Allergies Allergic to what:	☐ Yes	Age of diagnosis:	
Asthma	☐ Yes	Age of diagnosis:	
Frequent colds or flus	☐ 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:	
Traumatic Brain Injury/Loss of Consciousness	☐ Yes	Age of diagnosis:	
Morning headaches	☐ Yes	Age of diagnosis:	
Motor Disability (eg, 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/Chromosome Problem	☐ Yes	Age of diagnosis:	
Skeleton problem (e.g., dwarfism)	☐ Yes	Age of diagnosis:	
Craniofacial disorder (e.g. Pierre-Robin)	☐ Yes	Age of diagnosis:	
Thyroid Problems	☐ Yes	Age of diagnosis:	
Eczema (itchy skin)	☐ Yes	Age of diagnosis:	
Pain	☐ Yes	Age of diagnosis:	
Colic	☐ Yes	Age of diagnosis:	
Diabetes	☐ Yes	Age of diagnosis:	
Kidney Disease	☐ Yes	Age of diagnosis:	

PAST HISTORY		
Autism	☐ Yes	Age of diagnosis:
Developmental delay	☐ Yes	Age of diagnosis:
Hyperactivity/ADHD	☐ Yes	Age of diagnosis:
Anxiety/Panic Attacks (circle)	☐ Yes	Age of diagnosis:
Obsessive Compulsive Disorder	☐ Yes	Age of diagnosis:
Depression	☐ Yes	Age of diagnosis:
Suicide Attempt/Ideation (circle)	☐ 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 emotional or behavioral problems:		

MEDICATIONS		
Please list any medications your child currently takes:		
Medicine	Dose	How often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
List medications trialed for sleep:		
1.	2.	
3.	4.	

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 your child ever had his/her adenoids removed?	☐ Yes	☐ No	Age of surgery:
Has your child ever had ear tubes?	☐ Yes	☐ No	Age of surgery:
Please list any additional hospitalizations or surgeries: Date: Event:			

HEALTH HABITS			
Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)	☐ Yes How late: _____	☐ No	Amount per day:
For Teens:			
Does your teen smoke cigarettes at home or in the car?	☐ Yes	☐ No	Amount per day:
Does your teen drink alcohol or use illicit drugs?	☐ 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			
Does your child have an Individualized Education Plan (IEP) or 504 plan?	☐ Yes	☐ No			
Is your child enrolled in any special education classes?	☐ 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 late last year?					
Child's grades this year:	☐ Excellent	☐ Good	☐ Average	☐Poor	☐ Failing
Child's grades last year:	☐ Excellent	☐ Good	☐ Average	☐Poor	☐ Failing
Does your child fall asleep in class?	☐ Yes	☐ No	How often per Week?		
Do the teachers voice concerns about your child: Describe Concerns:	☐ Yes	☐ No			

Please Mark Under the Heading that Best Fits Your Child			
	Never (0)	**Sometimes (1)**	**Often (2)**
Complains of aches/pains			
Spends more time alone			
Tires easily, has little energy			
Fidgety, unable to sit still			
Has trouble with a teacher			
Less interested in school			
Acts as if driven by a motor			
Daydreams too much			
Distracted easily			
Is afraid of new situations			
Feels sad, unhappy			
Is irritable, angry			
Feels hopeless			
Has trouble concentrating			
Less interest in friends			
Fights with others			
Absent from school			
School grades dropping			
Is down on him or herself			
Visits doctor with doctor finding nothing wrong			
Has trouble sleeping			
Worries a lot			
Wants to be with you more than before			
Feels he or she is bad			
Takes unnecessary risks			
Gets hurt frequently			
Seems to be having less fun			
Acts younger than children their own age			
Does not listen to rules			
Does not show feelings			
Does not understand other people's feelings			
Teases others			
Blames others for his or her troubles			
Takes things that does not belong to them			
Refuses to share			

Total Score: _____

Does your child have any emotional or behavioral problems for which he/she needs help? ☐ Yes ☐ No

Are there any services that you would like your child to receive for these problems? ☐ Yes ☐ No

If yes, what services?

_____

_____

_____

FAMILY'S INFORMATION		
GUARDIAN 1		GUARDIAN 2
Age:		Age:
Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried		Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried
Education:		Education:
Work: ☐ Unemployed ☐ Part-time ☐ Full-Time		Work: ☐ Unemployed ☐ Part-time ☐ Full-Time
Occupation:		Occupation:

PERSON'S LIVING IN HOME		
Name:	Relationship: (parent, sibling, etc.)	Age:

Does the child sleep in more than one home setting: ☐ Yes ☐ No Arrangement: _____

FAMILY SLEEP HISTORY

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

If yes, mark the disorder (s):

Insomnia	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Depression/Anxiety/Bipolar (circle)	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent

How much sleep does mother need daily to function well? _____ hours

How much sleep does father need daily to function well? _____ hours

Sleep Log

Leave blank the periods your child is awake

Mark your child's bedtimes with arrows pointing downwards ↓

Fill in the times your child is asleep with shaded boxes

Mark the times your child gets up in the morning and after naps with arrows pointing upwards ↑

----------*PM*---------- ----------*AM*----------

DAY

noon **2:00** **4:00** **6:00** **8:00** **10:00** ***midnight*** **2:00** **4:00** **6:00** **8:00** **10:00** ***noon***

Children's of Minnesota