Children's Hospitals and Clinics of Minnesota

Delivering Next Generation Care

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 #:	

REFERRAL

Who asked that your child be seen by a sleep specialist?

- ☐ Child's parent or guardian
- ☐ Pediatrician/family physician Name: _____
- ☐ Surgical specialist (e.g., ENT) Name: _____
- ☐ Pediatric Specialist Name: _____
  (e.g., allergist, neurologist, pulmonologist)
- ☐ Mental health specialist Name: _____
  (e.g. psychiatrist, psychologist, social worker)
- ☐ School teacher, nurse, counselor
- ☐ Child himself/herself
- ☐ Other: Name: _____

What are your major concerns about your child's sleep?

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?

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 COMMENTS:
- 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..
☐ 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 parent's bed		☐ parent's room in parent's bed
☐ sibilng's room in own bed		☐ sibilng's room in own bed
☐ siblings room in sibling's bed		☐ siblings room in sibling's bed

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

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
Sound Machine/White Noise	☐ YES	☐ NO
TV	☐ YES	☐ NO
Computer	☐ YES	☐ NO
Video Game Device	☐ YES	☐ NO
Text	☐ YES	☐ NO
Pets in bed with child while sleeping	☐ YES	☐ NO

How long before lights out are electronics turned off:
_____ minutes/hours

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
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

Additional comments about sleep symptoms:

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
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

Modified Epworth Sleepiness Scale:

To assess how sleepy you are during the daytime, answer the questions below. Even if you haven't been in some of these situations, try and guess how they might affect you. Choose from the following answers:

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

If you can't relate to the word "doze", think about how likely it is that your eyelids would droop, you'd feel yourself "nodding off" or you'd actually fall asleep DURING THE DAYTIME during the activities listed below:

Situation	Chance of dozing (0 – 3)
1. Sitting and reading	_____
2. Watching TV	_____
3. Siting quietly in public, ie at church, the movies, etc.	_____
4. As a passenger in a car	_____
5. Lying down in the middle of the afternoon	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch	_____
8. As the driver of a car, while stopped in traffic for a few minutes	_____
Total:	_____

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 MEDICAL 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 Attempt/Ideation	☐ 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 psychologic, psychiatric, emotional, or behavioral problems:		

MEDICATIONS		
Please list any medications your child currently takes:		
Medicine	Dose	How often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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:			

HEALTH HABITS			
Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)	☐ Yes	☐ No	Amount per day:
For Teens:			
Does your teen smoke cigarettes at home or in the care?	☐ 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?	☐ No	☐ Yes			
Is your child enrolled in any special education classes?	☐ No	☐ Yes			
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

FAMILY'S INFORMATION

MOTHER		FATHER
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:

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
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

Birth Date: _____

Sleep Log

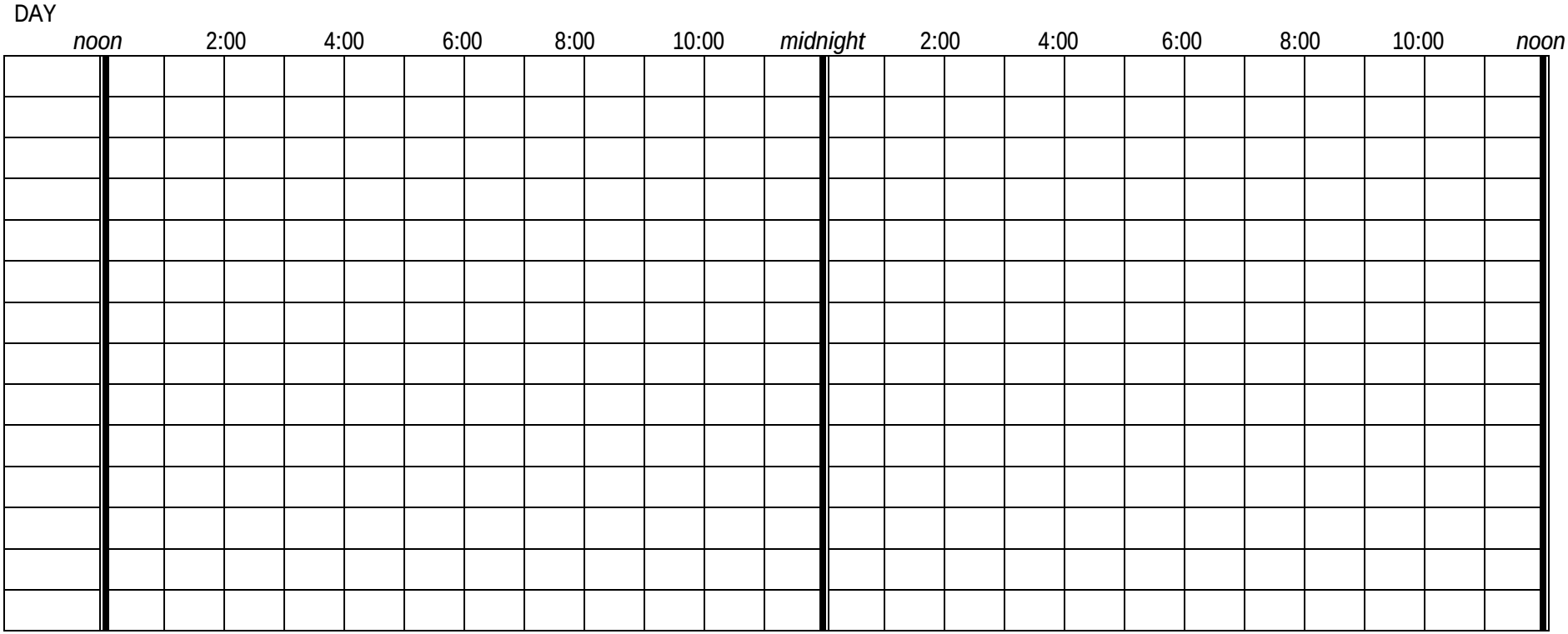
Leave blank the periods your child is awake

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----------



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