Child Sleep Questionnaire (3-12 years of age)

Please circle or fill in

1. Describe what the sleep problem is: ______________________________________________________

2. What is your child’s normal bedtime? __________ Wake up time: ______________

3. What positions does the patient sleep in? (check all that apply) □ Back □ Side □ Stomach

4. Has the child ever had a sleep study? □ YES □ NO
   If YES, what was the diagnosis and treatment? ____________________________________________

5. Please list current medications: _______________________________________________________

6. Does your child use medication for their sleep problem? □ YES □ NO
   If YES, please describe: ______________________________________________________________

7. Is there a family history of any of the following disorders? (check all that apply)
   □ Narcolepsy □ Sudden Infant Death Syndrome (SIDS) □ Sleep Terrors
   □ Excessive Daytime Sleepiness □ Bed Wetting □ Head Banging

8. Is your child sleepy during waking hours? □ YES □ NO

9. Is your child hyperactive during waking hours? □ YES □ NO

10. What is the child’s best time of day (when most alert)? _____________________________________

11. What is the worst time of day (when most sleepy)? ________________________________________

12. How many times a day does your child take naps? _________________________________________

13. Have you ever noted your child to have an over-powering, irresistible attack of sleep? □ YES □ NO
   If YES, describe how frequently this occurs and in what situations. ___________________________

14. Does your child ever lose muscle strength when excited, startled, angry, or laughing?
   (for example weakness in knees, sagging facial muscles or total collapse) □ YES □ NO

15. Does your child ever see or hear things that are not real as he/she goes to sleep or wakes up? □ YES □ NO

16. Do any family members have symptoms listed in the last three questions? □ YES □ NO

LAST, FIRST, MIDDLE ________________________________
DATE OF BIRTH ________________________________ GENDER: □ MALE □ FEMALE
MOTHER’S NAME ________________________________ FATHER’S NAME ________________________________
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Check any of the following that have been observed in the child

- Refuses to go to bed
- Awakens at night for a drink or feeding
- Repeatedly gets out of bed
- Awakens during night and gets into parent's bed
- Refuses to sleep alone
- Bangs head or rocks until asleep
- Cries until asleep
- Reluctant to go to sleep due to fears
- Has frightening dreams
- Insists on sleep with parents, etc.
- Can relate details of frightening dreams
- Talks in sleep
- Walks in sleep
- Grinds teeth in sleep
- Moves excessively during sleep
- Has jerking of arms or legs during sleep
- Snores or has labored breathing during sleep
- Stops breathing during sleep
- Wets bed during sleep
- Arouses screaming in terror
- Gets out of bed and urinates on floor
- Has seizures or convulsions during sleep
- Awakens at night for bathroom or diaper change
- Sleeps better away from home
- Requires nightlight
- Other: _______________

Comments

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