PHOENIX CHILDREN'S Medical Group

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.

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	☐ Asian−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?			

DOS:

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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): _____hours _____minutes

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 and vacations (add daytime and nighttime sleep): _____hours _____minutes

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 ☐ 6 ☐ 7

If child naps, write in usual nap time(s): Nap 1: ____: ____ ☐ a.m. ☐ p.m. to ____: ____ ☐ a.m. ☐ p.m.

Nap 2: ____: ____ ☐ 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 a parent present when your child falls asleep?	☐ yes ☐ no

Child usually falls asleep in...	Child sleeps most of the night in...	Child usually wakes in the morning in...
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ own room in own bed (alone)
☐ parents room in own bed	☐ parents room in own bed	☐ parents room in own bed
☐ parents room in parents bed	☐ parents room in parents bed	☐ parents room in parents bed
☐ sibling s room in own bed	☐ sibling s room in own bed	☐ sibling s room in own bed
☐ sibling s room in sibling s bed	☐ sibling s room in sibling s bed	☐ 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 difficult to awaken in the morning?	☐ yes ☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no

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Current Sleep Symptoms							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 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.	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							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 day a week)				
		(a) never (does not happen)					
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

SLEEP EVALUATION QUESTIONNAIRE

MEDICAL AND PSYCHIATRIC HISTORY			
PAST MEDICAL HISTORY			
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	Yes	Age of diagnosis:	Allergic to what:
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:	
Morning headaches	Yes	Age of diagnosis:	
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	Yes	Age of diagnosis:	
Chromosome problem (e.g., Down?s)	Yes	Age of diagnosis:	
Skeleton problem (e.g., dwarfism)	Yes	Age of diagnosis:	
Cranofacial 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:	

SLEEP EVALUATION QUESTIONNAIRE

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.

_____

_____

_____

_____

CURRENT MEDICAL HISTORY

Please list any medications your child currently takes:

	Medicine	Dose	How often?
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. _____

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SURGERIES/HOSPITALIZATIONS			
Has your child ever had his/her tonsils removed?	☐ No	☐ Yes	Age of surgery:
Has your child ever had his/her adenoids removed?	☐ No	☐ Yes	Age of surgery:
Has your child ever had ear tubes?	☐ No	☐ Yes	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)	☐ No	☐ Yes	Amount per day:

PREGNANCY/ DELIVERY							
Pregnancy	☐ Normal	☐ Difficult					
Delivery	☐ Term	☐ Pre−term	☐ Post−term				
Child s birth weight:							
Only child?	☐ Yes	☐ No	If no, circle birth order:	1st	2nd	3rd	4th 5th 6th 7th

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 class?	☐ 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 so far this 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

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FAMILY S INFORMATION		
MOTHER		**FATHER**
Age:		Age:
Marital Status ☐ Single ☐ Divorced ☐ Separated		Marital Status ☐ Single ☐ Divorced ☐ Separated
☐ Married ☐ Widowed ☐ Remarried		☐ Married ☐ Widowed ☐ Remarried
Education:		Education:
Work: ☐ Unemployed ☐ Part−time ☐Full−time		Work: ☐ Unemployed ☐ Part−time ☐ Full−time
Occupation:		Occupation:

PERSONS IN HOME		
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 leg sydrome	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking/sleep terror	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleeptalking	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent

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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 teacher, nurse, counselor

_____ Child himself/herself

_____ Other:

Signature of Patient/Legally Authorized Representative

Date & Time

Printed Name of Patient/Legally Authorized Representative

Relationship to Patient

Practitioner Signature

Date & Time

Printed Name