Akron Children's Hospital

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?

SLEEP HISTORY
Weekday Sleep Schedule
Write in the amount of time child sleeps during a 24-hour period during *weekdays* (add daytime and night- time 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 night- time sleep):_____ hours _____minutes
The child's usual bedtime on *weekend/vacation nights:*_____:_____
The child's usual *waketime* on *weekday mornings*:_____:_____

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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…. ☐ own room in own bed (alone) ☐ parents' room in own bed ☐ parents' room in parent's bed ☐ sibling's room in own bed ☐ sibling's room in sibling's bed	Child sleeps *most of the night in….* ☐ own room in own bed (alone) ☐ parents' room in own bed ☐ parents' room in parent's bed ☐ sibling's room in own bed ☐ sibling's room in sibling's bed	Child usually *wakes in the morning* in…. ☐ own room in own bed (alone) ☐ parents' room in own bed ☐ parents' room in parent's bed ☐ sibling's room in own 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 a poor sleeper? ☐ yes ☐ no **If yes**, do you think this is a problem? ☐ yes ☐ no		

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

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:	Allergies to what:
Asthma	Yes	Age of diagnosis:	

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MEDICAL AND PSYCHIATRIC HISTORY (cont'd)	
Frequent colds or flus	☐ Yes Age of diagnosis:
Frequent ear infections	☐ Yes Age of diagnosis:
Frequent strep throat infections	☐ Yes Age of diagnosis:
Difficulty sleeping	☐ 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:
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:
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.
SURGERIES/HOSPITALIZATIONS
Has your child ever had his/her tonsils removed? ☐ Yes Age of surgery:
Has your child ever had his/her adenoids removed? ☐ Yes Age of surgery:
Has your child ever had ear tubes? ☐ 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:
SCHOOL PERFORMANCE
CURRENT SCHOOL PEFORMANCE (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 ☐ 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:

PERSONS LIVING IN HOME

Name	Relationship	Age

FAMILY SLEEP HISTORY

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

If yes, mark the disorder

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 you 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, pulmonlogist)_____

Mental Health Specialist (e.g., psychiatrist, psychologist, social worker)_____

School teacher, nurse, counselor_____

Child himself/herself_____

Other_____

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Patient Name:_____ Date of Birth:_____

Appendix A. SLEEP DISTURBANCES SCALE FOR CHILDREN

INSTRUCTIONS*: This questionnaire will allow to your doctor to have a better understanding of the sleep-wake rhythm of your child and of any problems in his/her sleep behavior. Try to answer every question; in answering, consider each question as pertaining to the* ***past 6 months*** *of the child's life. Please answer the questions by circling or striking the number 1 to 5.* Thank you very much for your help.

1. How many hours of sleep does your child get on most nights.	1 *9-11 hours*	2 *8-9 hours*	3 *7-8 hours*	4 *5-7 hours*	5 *less than 5 hours*
2. How long after going to bed does your child usually fall asleep	1 *less than 15'*	2 *15-30'*	3 *30-45'*	4 *45-60'*	5 *more than 60'*

					5 **Always (daily)**
				4 **Often (3 or 5 times per week)**	
			3 **Sometimes (once or twice per week)**		
		2 **Occasionally (once or twice per month or less)**			
	1 **Never**				
3. The child goes to bed reluctantly	1	2	3	4	5
4. The child has difficulty getting to sleep at night	1	2	3	4	5
5. The child feels anxious or afraid when falling asleep	1	2	3	4	5
6. The child startles or jerks parts of the body while falling asleep	1	2	3	4	5
7. The child shows repetitive actions such as rocking or head banging while falling asleep	1	2	3	4	5
8. The child experiences vivid dream-like scenes while falling asleep	1	2	3	4	5
9. The child sweats excessively while falling asleep	1	2	3	4	5
10.The child wakes up more than twice per night	1	2	3	4	5
11.After waking up in the night, the child has difficulty to fall asleep again	1	2	3	4	5
12. The child has frequent twitching or jerking of legs while asleep or often changes position during the night or kicks the covers off the bed.	1	2	3	4	5
13. The child has difficulty in breathing during the night	1	2	3	4	5
14.The child gasps for breath or is unable to breathe during sleep	1	2	3	4	5
15.The child snores	1	2	3	4	5
16.The child sweats excessively during the night	1	2	3	4	5
17.You have observed the child sleepwalking	1	2	3	4	5
18.You have observed the child talking in his/her sleep	1	2	3	4	5
19.The child grinds teeth during sleep	1	2	3	4	5
20.The child wakes from sleep screaming or confused so that you cannot seem to get through to him/her, but has no memory of these events the next morning	1	2	3	4	5
21.The child has nightmares which he/she doesn't remember the next day	1	2	3	4	5
22.The child is unusually difficult to wake up in the morning	1	2	3	4	5
23.The child awakes in the morning feeling tired	1	2	3	4	5
24.The child feels unable to move when waking up in the morning	1	2	3	4	5
25.The child experiences daytime somnolence	1	2	3	4	5
26.The child falls asleep suddenly in inappropriate situations	1	2	3	4	5

FOR OFFICE USE ONLY BELOW THIS LINE	
Disorders of initiating and maintaining sleep (sum the score of the items 1,2,3,4,5,10,11)	
Sleep Breathing Disorders (sum the score of the items 13,14,15)	
Disorders of arousal (sum the score of the items 17,20,21)	
Sleep-Wake Transition Disorders (sum the score of the items 6,7,8,12,18,19)	
Disorders of excessive somnolence (sum the score of the items 22,23,24,25,26)	
Sleep Hyperhydrosis (sum the score of the items 9,16)	
Total score (sum 6 factors' scores)	

After summing the scores for the different scales report the values in the scoring sheet in order to obtain a sleep profile

Sleep Disturbances Scale for Children Bruni et al., (1996)