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Please fill in and bring with
you to your appointment

SLEEP QUESTIONNAIRE (for children & adolescents up to age 15)

Name _____ Sex M F Today's Date _____

Birth date _____ Age _____ Height _____ ft. _____ ins. Weight _____ lbs.

Mother's Name _____ Father's Name _____ Parents Live Together? Y N

Child's Doctor _____ Year in School _____ School Start Time _____

Parent's Day telephone _____ Parent's Evening telephone _____

Circle the most appropriate answers in the questionnaire:

DK means **Don't Know**

NA means **Not Applicable** (use **NA** for adolescents if question is about younger children)

Please describe as briefly as possible your child's main problem. _____

How long ago did this problem begin? _____ years / months ago

Has your child had a sleep laboratory study before? YES NO

If yes, where and when? _____

Was any treatment prescribed because of results from the sleep study? YES NO

Please explain. _____

Has your child been prescribed any other treatment for sleep problems?

If so, what treatment and what effects has it had? _____

• Your Child's and Family's Medical History

Medicine allergies _____

Current Medication Name	Dose	Time Taken	Reason?	Helpful?
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has your child ever had:

Tonsils out?	YES	NO
Adenoids out?	YES	NO
A broken nose?	YES	NO
Nasal or sinus surgery?	YES	NO
A head injury?	YES	NO
Any other surgery?	YES	NO (what type?) _____

If yes, please describe _____

Any problems with mom's pregnancy that affected your child? _____

Check if your child had/has:

_____ problems at birth	_____ frequent coughing
_____ infant colic	_____ frequent sinus problems
_____ developmental delays	_____ shortness of breath with exercise
_____ history of seizures	_____ pollen, dust or animal allergies
_____ diabetes	_____ indigestion, gas or heart burn
_____ high blood pressure	_____ an ulcer or hiatal hernia
_____ heart problems (specify) _____	_____ underactive thyroid
_____ lung problems (specify) _____	_____ overactive thyroid

Describe any problems checked and **list other important medical & surgical history:** _____

Has your child ever been treated for depression, anxiety, bipolar disorder, attention deficit disorder or other similar problem? YES NO

If so, what was the problem or diagnosis? _____

Any family history of sleep problems? _____



Please list medications your child has been prescribed **in the past** to help with a sleep problem.

Past Medication Name	Dose	How Long Used?	Helpful?	Why Stopped?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please give the following family information:

	Age	Illnesses
Mother	_____	_____
Father	_____	_____
Brother	_____	_____
Brother	_____	_____
Sister	_____	_____
Sister	_____	_____

Please list illnesses that run in the family (diabetes, hypertension, heart disease, psychiatric, etc.)

Condition	Family Member(s)	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Habits for your child

Caffeine (coffee/tea/soda)? **YES NO** If yes, what and how much? _____
Tobacco? **YES NO** If yes, what and how much? _____
Alcohol? **YES NO** If yes, what and how much? _____
Drug use? **YES NO** If yes, what and how much? _____

• Your Child's Sleep Routines

Describe what your child usually does during the last 30 minutes before bedtime.

Does your child share a bedroom with anyone? **YES NO**
If yes, with whom? _____

Does s/he have trouble relaxing and feeling ready for bed? **YES NO**

As the sleep period approaches, does your child become more alert? **YES NO**

Will your child fall asleep in bed alone? **YES NO**

In order to sleep, does your child often need a special toy or object? **YES NO**

If yes, describe: _____

Does your child often need a bottle in order to go to sleep? **YES NO NA**

What type of bed does your child sleep in? **Crib Twin Bed Double Bed Other**

Does a parent or the child turn off the light? **Parent Child**

Does your child do any of the following in bed before going to sleep?

Read **Yes No** How long? _____

Watch TV **Yes No** What time is it turned off? _____

Listen to music **Yes No** What time is it turned off? _____

Other _____

Does s/he seem to sleep well at night? **YES NO**

If not, why not? _____

What position(s) does s/he sleep in? _____

Any unusual positions of head or neck? _____

Is your child bothered by noises at night? **YES NO**

If yes, please explain: _____

As an infant, did your child require any of the following to get to sleep?

Swing / Snuggly / Car Ride / Being Held / Other: _____

Please fill in the boxes in the table below. We want to know what your child's sleep schedule is usually like and also how it might vary. Please write down the time s/he *usually* gets into bed, along with the earliest and latest times s/he might get into bed. Do the same for the time the lights are turned out and so on.

	Usual	Earliest	Latest
Time child is in bed			
Lights out time			
Minutes to get to sleep			
Wake up time			
Get out of bed time			

Do the times you recorded on the table change on the weekends? **YES** **NO**

If so, what changes and how much? _____

How many times does s/he wake up on an average night? _____

How long does it take him/her to get back to sleep after waking up? _____

How many naps does s/he take each day, and how long do they last? _____

What time of day do the naps occur? _____

If there are no naps, what time of day does your child feel most tired? _____

What time of day does your child seem most alert? _____

• Problems when FALLING ASLEEP

If your child has trouble falling asleep, what do you think prevents sleep?

Fears / Loneliness / Not sleepy / Worries / Family Problems / Other: _____

Do you get annoyed or angry when your child cannot sleep? **YES** **NO**

How often does your child cry himself/herself to sleep? _____

Do you ever let your child cry in bed in order to get to sleep? **YES** **NO**

If yes, how long do you let your child cry? _____

When unable to fall asleep, does your child get out of bed? **YES** **NO**

If yes, how long after getting into bed? _____

Once out of bed, what does your child do? _____

Have you noticed your child's head or whole body rocking from side to side at night? **YES** **NO**

If yes, please describe; how often does this occur and at what time of night? _____

Does your child complain of aching, itchy or burning legs at bedtime? **YES** **NO** **DK**

Does your child move legs or arms around in bed a lot before sleep? **YES** **NO** **DK**

Is your child unable to lie still at night, even if you are reading to or talking with him/her? **YES** **NO**

• Problems DURING YOUR CHILD'S SLEEP

Does your child toss and turn in bed? **YES** **NO**

Do your child's legs or arms jerk or twitch while asleep? **YES** **NO** **DK**

Has a relative had any of these symptoms or been diagnosed with restless legs syndrome? **YES** **NO** **DK**

Does your child snore? **YES** **NO**

If so, does the snoring occur every night? **YES** **NO**

If not, how often does it occur? _____

What percentage of the night would you say that your child snores? _____

Would you say the snoring is: **mild** **moderate** **severe** **can be heard from the next room?**

Have you ever seen your child stop breathing while asleep? **YES** **NO**

If yes, for how long? _____

Does your child have nightmares? **YES** **NO**

If yes, at what age did they begin? _____

How often do they occur? _____

Does your child ever awaken suddenly with a scream and appear inconsolable? **YES** **NO**

If yes, at what age did it begin? _____

How often? _____

Does your child sleepwalk? **YES** **NO**

If yes, at what age did it begin? _____

How often? _____

If your child sleepwalks, has s/he ever injured himself/herself or someone else? **YES** **NO**

Does your child eat during the night without remembering it in the morning? **YES** **NO**

Does your child ever fall out of bed or have unusual movements during sleep? **YES** **NO**

Does your child occasionally wet the bed? **YES** **NO**

If yes, how often? _____

My child's sleep seems frequently disturbed by: (check all that are true)

- | | |
|--|--|
| <input type="checkbox"/> heat or cold | <input type="checkbox"/> indigestion, gas or heartburn |
| <input type="checkbox"/> light | <input type="checkbox"/> choking |
| <input type="checkbox"/> noise | <input type="checkbox"/> hunger (need to get up and eat while awake) |
| <input type="checkbox"/> others in the house | <input type="checkbox"/> thirst (need to get up for water? other drink?) |
| <input type="checkbox"/> asthma | <input type="checkbox"/> need to urinate |
| <input type="checkbox"/> cough | <input type="checkbox"/> leg discomfort |

Other: _____

• Problems with WAKING FOR THE DAY

How does your child seem on awakening in the morning? _____

Is it hard to wake your child up in the morning? **YES** **NO** Describe _____

How does a poor night's sleep affect your child the next day? _____

Do you think a poor night's sleep affects your child's school performance the next day? **YES** **NO**

Has a teacher commented on this? **YES** **NO**

• Problems in the DAYTIME

Does your child ever suddenly get physically weak or fall right after either laughing hard, getting really angry or making a sudden physical exertion? **YES NO**

Does your child ever seem to realize that s/he doesn't know how s/he got somewhere or have no memory for a task s/he just completed? **YES NO**

Please explain any "YES" answers from above: _____

Is your child often too sleepy in the daytime? **YES NO**

(Please fill out the Sleepiness Scale on the last page.)

• DESIRED SLEEP BEHAVIORS

At what time would you **like** your child to fall asleep? _____

For how long would you like your child to sleep? _____

What time would you like your child to awaken in the morning? _____

For how long do you feel other children of your child's age sleep? _____

• OTHER IMPORTANT HISTORY

Please list all people whom you have consulted about your child's problem.
List name of provider, what was done and the outcome of any treatment.

Please describe anything else that you think may be important in understanding problems your child is having with sleep, sleepiness or daytime behavior. This will greatly assist in contributing to your child's care.

It is usually desirable to share the results of a sleep disorders consultation with your child's primary care doctor and any relevant specialist physicians that s/he sees. I would like, but do not require, your permission to send a copy of the consultation report and any other pertinent records such as progress notes or sleep laboratory study results to those doctor(s). This permission would be granted on a separate "records release" form, if you agree.

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(2/21/09)

Pediatric Daytime Sleepiness Scale

(for children 15 or younger)

Drake et al. (2003) Sleep, Vol. 26, pp. 455-458

How often do you fall asleep or get drowsy during class periods?

Always Frequently Sometimes Seldom Never

How often do you get sleeping or drowsy while doing your homework?

Always Frequently Sometimes Seldom Never

Are you usually alert most of the day?

Always Frequently Sometimes Seldom Never

How often are you ever tired and grumpy during the day?

Always Frequently Sometimes Seldom Never

How often do you have trouble getting out of bed in the morning?

Always Frequently Sometimes Seldom Never

How often do you fall back to sleep after being awakened in the morning?

Always Frequently Sometimes Seldom Never

How often do you need someone to awaken you in the morning?

Always Frequently Sometimes Seldom Never

How often do you think that you need more sleep?

Always Frequently Sometimes Seldom Never