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PATI QUE

Please complete this questionnaire and bring it with you to the sleep study appointment you have scheduled for your child.

In answering the questions be as complete as possible. The more information that is given the more complete the evaluation of your child's sleep will be.

Please give detailed answers and any additional information you think would be helpful in the space provided.

**Circle the most appropriate answers in the questionnaire.
 DK = don't know NA = not applicable**

We look forward to being able to evaluate your child's sleep and to be able to provide your physician with the answers needed for treatment.

1. Please describe in your own words as briefly as possible your child's main problem.

2. When was the first time this problem began? _____ Months/Years ago

3. List any medications that your child is currently taking to help with the sleep problem:

Medication	Dose	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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



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5. Does your child do any of the following in bed at night?
Read Yes No
Watch TV Yes No
Listen to the Radio Yes No
Other _____
6. Will your child fall asleep alone in bed? Yes No
7. In order to sleep, does your child often need a special toy or object? Yes No
If so, describe _____
8. Does your child often need a bottle in order to go to sleep? Yes No
9. What type of bed does your child sleep in?
 Crib Single Bed Double Bed Other _____
10. Does your child sleep alone? Yes No
If not, with whom? _____
11. Which side of the body does your child sleep on most of the time?
 Left side Right side Back Face Down
12. What time is the bedroom light turned off? _____ am / pm
13. Does the parent or child turn light off? Parent Child
14. Is your child bothered by environmental noises at night? Yes No
If so, please explain _____

15. As an infant, was your child "colicky"? Yes No
16. As an infant, did your child require any of the following devices to go to sleep?
 Swing Snuggly Car Ride Being held Other _____
17. On average how long does it take your child to fall asleep? _____hrs _____mins
18. What is the quickest time it has taken your child to fall asleep in the last 2 weeks?
_____hrs _____mins
19. What is the longest time it has taken your child to fall asleep? _____hrs _____mins
20. What do you think prevents your child from falling asleep?
 Fears Loneliness Not sleepy Worries Other _____
21. Do you get annoyed/angry when your child can't sleep? Yes No



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22. How often does your child cry him/herself to sleep? _____ times per week

23. Do you ever let your child cry in bed in order to get to sleep? Yes No

If so, how long do you let the child cry?

10 min 20 min 30 min As long as it takes

24. When unable to fall asleep, does your child get out of bed? Yes No

If so, how long after getting into bed? _____hrs _____mins

Once out of bed, what does your child do?

How long is your child usually up? _____hrs _____mins

25. If the child does not get out of bed, how long does it take to fall back to sleep?

_____hrs _____mins

26. Once having fallen asleep, how long does your child sleep? _____hrs _____mins

27. Does your child awaken during the night? Yes No

If so, on average how long will your child be awake? _____hrs _____mins

How often does your child awaken during the night? _____times

28. What time does your child finally awaken in the morning? _____am

29. What time does your child get out of bed in the morning? _____am

30. How does your child seem upon awakening in the morning?

31. How does a poor nights sleep affect your child the next day?

32. Does your child feel sleepy during the day? Yes No

33. Does your child nap during the day? Yes No

If so, how often and for how long? _____# of Times _____hrs _____mins

34. What time of day does your child usually nap? Time _____ am / pm

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

_____am _____pm

36. What time of day does your child seem most alert? _____am _____pm



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37. As the sleep time approaches, does your child become more alert? Yes No
38. Do you think a poor night's sleep affects your child's school performance the next day? Yes No
Has the teacher commented on this? Yes No
39. Does your child toss and turn in bed? Yes No
40. Have you ever noticed your child's head rocking from side to side at night? Yes No

If so, please describe: _____

How often does this behavior occur? _____ times

What time of night is this activity likely to occur? _____ am / pm

41. Does your child complain of aching legs at bedtime? Yes No
42. Does your child move his/her legs around in bed at night? DK Yes No
43. Do your child's legs jerk while he is asleep at night? DK Yes No
44. Does your child have nightmares? Yes No
If so, at what age did they begin? _____ years
How often do they occur? _____ times per night/ week/ month
45. Does your child ever awaken suddenly with a scream and appear inconsolable? DK Yes No
If so, how often? _____ times per night/ week/ month
46. Does your child sleepwalk? Yes No
If so, how often? _____ times per night/ week/ month
If your child sleepwalks, has he ever injured himself? Yes No
47. Does your child ever wet the bed? Yes No
If so, how often? _____ times per night/ week/ month
48. Does your child snore at night? Yes No
Does the snoring occur every night? Yes No
If not, how often does it occur? _____ times per week/ month
49. Does your child ever seem to stop breathing while asleep? Yes No
If so, for how long? _____ seconds
50. Has your child ever had a tonsillectomy or adenoidectomy? Yes No
If so, please give the date. _____ / _____ / _____



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51. Please state when your child was last able to sleep consistently without any problems.
 Never _____ years/months ago

What time did your child then go to bed? _____ pm

How long did it take for your child to fall asleep _____ mins

Did your child awaken during the night? Yes No

If so, how often and for how long? Times _____ mins

What time did your child awaken in the morning? _____ am

52. At what time would you like your child to fall asleep now? _____ pm

53. How long would you like your child to sleep? _____ hours

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

55. For how long do you think normal children of your child's age sleep? _____ hours

56. Do you consider your child's sleep problem to be:

Mild Moderate Severe

57. Please add any additional comments about your child's sleep problem that you think are relevant.

58. Please list all the people whom you have consulted about your child's sleep problem. Starting with the first, list the date, name, degree, specialty, investigations, treatment, and outcome of all treatments.

Date	Name	Degree/Specialty	Investigations	Treatment
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



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59. Please list all medical illnesses that your child has been treated for in the past or is now under treatment for. Give date, name of illness, treatment, and outcome.

Date	Illness	Treatment	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

60. Please list any operations your child has had.

Date	Operations
_____	_____
_____	_____
_____	_____
_____	_____

61. Please list any medications your child has been prescribed in the past to help with the sleep problem. Give the name, dosage, time they were taken, how long they were taken, any beneficial effects, why they were stopped. Start with the first one taken.

Medication	Dose	Time	Length	Effect	Stopped
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



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62. Please give the following family information

Age Illness

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

63. Please list any illnesses that run in the family such as diabetes, hypertension, heart disease, psychiatric disorders, sleep problems, etc.

Condition	Family Member	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Completed By: _____ Date: _____