SLEEP QUESTIONNAIRE

Name:_____Chart#:_____
Completed by:_____Relationship:_____Date:_____

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

   _____
   _____
   _____
   _____

2. When was the very first time this problem began?_____(months/years ago)
3. Describe what your child usually does during the last 30 minutes before bedtime.

   _____
   _____
   _____
   _____

4. During the **week**, my child starts getting ready for bed at:

   _____o'clock.

5. Gets in bed at:

_____o'clock.

Lights out at:

_____o'clock.

Falls asleep at:

_____o'clock.

Gets up at:

_____o'clock.

How many hours of sleep does your child usually get?

_____

During the **weekend**, my child starts getting ready for bed at:

_____o'clock.

Gets in bed at:

_____o'clock.

Lights out at:

_____o'clock.

Falls asleep at:

_____o'clock.

Gets up at:

_____o'clock.

How many hours of sleep does your child usually get?

_____

6. Does your child do any of the following in bed at night?

Read	Yes ☐	No ☐
Watch TV	Yes ☐	No ☐
Listen to radio	Yes ☐	No ☐

Other:_____

7. Will your child fall asleep alone in bed?

☐ Yes / No ☐

8. What type of bed does your child sleep in?

Single bed ☐ Double bed ☐ Futon ☐ Sofa ☐ Other:_____

9. Does your child sleep alone?

☐ Yes / No ☐

If not, who with?_____

Who does your child share a bedroom with?_____

10. My child falls asleep in his/her bed:

Nightly ☐ Weekly ☐ Rarely ☐ Never ☐

11. My child falls asleep in his/her parent's bed:

Nightly ☐ Weekly ☐ Rarely ☐ Never ☐

12. My child needs a parent in his/her room to fall asleep:

Nightly ☐ Weekly ☐ Rarely ☐ Never ☐

13. My child awakens at night and stays in his/her bed:

Nightly ☐ Weekly ☐ Rarely ☐ Never ☐

If not whose bed does your child go to?_____

14. Which side of the body does your child sleep on?

Left side ☐ Right side ☐ Back ☐ Stomach ☐

15. Is your child bothered by environmental noises?

☐ Yes / ☐ No Sometimes ☐

16. What is the quickest time it has taken your child to fall asleep in the last two weeks?

_____Hrs. _____Min.

17. What is the longest time it has taken your child to fall asleep in the last two weeks?

_____Hrs. _____Min.

18. What do you think prevents your child from falling asleep?

☐ Fears ☐ Loneliness ☐ Not Sleepy ☐ Worries Other:_____

19. Do you get annoyed/angry when your child cannot sleep?

☐ Yes / No ☐

20. When unable to fall asleep, does your child get out of bed?

☐ Yes / No ☐

If so, how long after getting into bed:

_____Hrs. _____Min.

21. Once out of bed, what does your child do?

_____

_____

22. How long is your child up for?

_____Hrs. _____Min.

23. When your child returns to bed, how long does it take to fall asleep again?

_____Hrs. _____Min.

24. If your child does not get out of bed, how long does it take to fall back asleep?

_____Hrs. _____Min.

25. Once having fallen asleep, how long does your child sleep for?

_____Hrs. _____Min.

26. Does your child awaken during the night?

Yes / No Sometimes

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

_____Hrs. _____Min.

27. How often does your child awaken during the night?_____Times

28. How rested does your child seem on awakening in the morning?

_____

29. Does your child have new symptoms when awakening, like headache, cough, gasping for air?

_____

30. Does your child feel sleepy during the day?

Yes / No

31. Does your child nap during the day?

Yes / No

If so, what time and for how long?_____

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

Morning Afternoon Evening

33. What time of day does your child seem most alert?

AM / PM

34. During the day, does your child fall asleep at school, afterschool, watching TV, or in the car?

Yes / No

35. As the sleep period approaches, does your child become more alert?

Yes / No

36. Please state when your child was last able to sleep consistently without any problems:

Never _____Years Old _____Months Old

37. My child exercises:

Yes / No

If yes, what type of exercise and how often?

_____

_____

_____

_____

38. Fluid intake:

What does your child drink in a 24 hour period? List the amounts, type of beverage, and times.

Type of Beverage	Amount	Time Child Drank Beverage
1.		
2.		
3.		
4.		
5.		

Current Sleep Symptoms

Please rate how often your child:	Never	Sometimes	Always	Don't Know
Stops breathing during the night				
Has difficulty breathing while sleeping				
Snores				
Sweats while sleeping				
Has nightmares				
Sleepwalks				
Sleep talks				
Kicks legs while sleeping				
Tosses and turns while sleeping				
Complains of growing pains in his/her legs				
Eats or drinks without full awareness during the Night				
Grinds his/her teeth				
Wets bed				
Hurts himself/herself during sleep				
Feels weak or loses muscle tone with strong Emotions				
Sees frightening images when falling asleep				

School Performance

How many school days has your child missed this year?_____

Last year?_____

Family Sleep History

Does anyone in the child's family have a sleep disorder?

Yes / No

If yes, mark the disorder and relationship:

Insomnia	mother	father	sibling	grandparent
Snoring	mother	father	sibling	grandparent
Sleep Apnea	mother	father	sibling	grandparent
Restless Leg Syndrome	mother	father	sibling	grandparent
Period Limb Movement Disorder	mother	father	sibling	grandparent
Sleep Walking/Sleep Terrors	mother	father	sibling	grandparent
Sleep Talking	mother	father	sibling	grandparent
Narcolepsy	mother	father	sibling	grandparent
Other:_____	mother	father	sibling	grandparent

39. At what time would you like your child to fall asleep now?

    _____pm

40. How long would you like your child to sleep for?

    _____hours

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

    _____am

42. For how long do you think normal children of this age should sleep?

    _____hours

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

    Mild Moderate Severe

44. Please add any other comments about your child's/teen's sleep problem that you think are relevant: