A-S-N
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Pediatric Sleep Evaluation Questionnaire

Directions:

Please answer each of the following questions by writing in or choosing the best answer. This will help us better understand your child's sleep concerns, interpret the sleep study, and provide treatment recommendations.

CHILD'S INFORMATION			
Child's name:		Child's gender:	
Child's birthdate/age:		Child's height/weight:	
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 with your child's sleep?			

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

General Sleep Continued			
Child resists going to bed?	☐ yes ☐ no	I**f 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

Current Sleep Symptoms				
		Yes	**No**	**Specific Concern**
1.	Difficulty breathing when asleep			
2.	Stops breathing during sleep			
3.	Snores			
4.	Restless sleep			
5.	Sweating when sleeping			
6.	Excessive sleepiness			
7.	Poor appetite			
8.	Nightmares			
9.	Sleepwalking			
10.	Sleep talking			
11.	Screaming in his/her sleep			
12.	Kicks legs in sleep			
13.	Wakes up at night			
14.	Gets out of bed at night			
15.	Trouble staying in his/her bed			
16.	Resists going to bed at bedtime			
17.	Grinds his/her teeth			
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling			
19.	Wets bed			

Current Daytime Symptoms				
		Yes	**No**	**Specific Concern**
1.	Trouble getting up in the morning			
2.	Falls asleep in school			
3.	Naps after school			
4.	Daytime sleepiness			
5.	Feels weak or loses control of his/her muscles with strong emotions			
6.	Reports unable to move when falling asleep or upon waking			
7.	Sees frightening visual images before falling asleep or upon waking			
8.	Growing / leg pains			

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

MEDICAL AND PSYCHIATRIC HISTORY		
PAST MEDICAL HISTORY (check "yes" for all that apply)		
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 flu's	☐ 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 (gastro esophageal 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 Syndrome)	☐ 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:
Chiari Malformation/Spina Bifida	☐ 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.		
1.		
2.		
3.		

CURRENT MEDICATIONS		
Please list any medications your child currently takes: Medicine	Dose	How often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

LONG-TERM MEDICAL PROBLEMS
1.
2.
3.
4.
5.
6.
7.
8.

SURGERIES/HOSPITALIZATIONS				
Has your child ever had his/her tonsils removed?	☐ No	☐ Yes	Age at surgery:	_____
Has your child ever had his/her adenoids removed?	☐ No	☐ Yes	Age at surgery:	_____
Has your child ever had ear tubes?	☐ No	☐ Yes	Age at 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 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 classes?	☐ 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

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(s):

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
Bed-wetting	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Thyroid disturbance	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
High blood pressure	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Diabetes	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Anxiety disorder	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent

FAMILY SLEEP HISTORY CONTINUED				
Depression	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Other psychiatric disturbances	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Obesity	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Other: _____	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent

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: _____

Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month, not necessarily during the past fewdays since these may not have been typical if your child has not been well. You should circle the correct response in the space provided.

"Y" means "yes," "N" means "no," and "DK" means "don't know"

1. WHILE SLEEPING, DOES YOUR CHILD:			
Snore more than half the time?	Y	N	DK
Always snore?	Y	N	DK
Snore loudly?	Y	N	DK
Have "heavy" or loud breathing?	Y	N	DK
Have trouble breathing, or struggle to breathe?	Y	N	DK
2. HAVE YOU EVER SEEN YOUR CHILD STOP BREATHING DURING THE NIGHT?	Y	N	DK
3. DOES YOUR CHILD:			
Tend to breathe through the mouth during the day?...	Y	N	DK
Have a dry mouth on waking up in the morning?	Y	N	DK
Occasionally wet the bed?	Y	N	DK
4. DOES YOUR CHILD:			
Wake up feeling unrefreshed in the morning?	Y	N	DK
Have a problem with sleepiness during the day?	Y	N	DK
5. HAS A TEACHER OR OTHER SUPERVISOR COMMENTED THAT YOUR CHILD APPEARS SLEEPY DURING THE DAY?	Y	N	DK
6. IS IT HARD TO WAKE YOUR CHILD UP IN THE MORNING?	Y	N	DK
7. DOES YOUR CHILD WAKE UP WITH HEADACHES IN THE MORNING?	Y	N	DK
8. DID YOUR CHILD STOP GROWING AT A NORMAL RATE AT ANY TIME SINCE BIRTH?	Y	N	DK
9. IS YOUR CHILD OVERWEIGHT?	Y	N	DK
10. THIS CHILD **OFTEN**:			
Does not seem to listen when spoken to directly	Y	N	DK
Has difficulty organizing tasks and activities.	Y	N	DK
Is easily distracted by extraneous stimuli	Y	N	DK
Fidgets with hands or feet or squirms in seat	Y	N	DK
Is "on the go" or often acts as if "driven by a motor".	Y	N	DK
Interrupts or intrudes on others (eg., butts into conversations or games)	Y	N	DK

QUESTIONNAIRE INFO		
Date questionnaire filled out:	Questionnaire filled out by:	Relationship to patient: