



ADVANCED SLEEP LABS
525 N. Keene St., Suite 302
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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:	Child's age:
Child's racial/ethnic background:	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian-American <input type="checkbox"/> Native-American <input type="checkbox"/> Hispanic-Latino <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other
What are your major concerns about your child's sleep?	
What things have you tried to help with your child's sleep?	

General Sleep Continued			
Child resists going to bed?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child has difficulty falling asleep?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child awakens during the night?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
After nighttime awakening, child has difficulty falling back to sleep?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child is difficult to awaken in the morning?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child is a poor sleeper?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> 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	<input type="checkbox"/> Normal	<input type="checkbox"/> Difficult		
Delivery	<input type="checkbox"/> Term	<input type="checkbox"/> Pre-term _____ wks	<input type="checkbox"/> Post-term _____ wks	
Child's birth weight:	_____ lbs	_____ oz		
Only child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, circle birth order: 1 st 2 nd 3 rd 4 th 5 th 6 th 7 th	

MEDICAL AND PSYCHIATRIC HISTORY

PAST MEDICAL HISTORY (check "yes" for all that apply)

Frequent nasal congestion	<input type="checkbox"/> Yes	Age of diagnosis:
Trouble breathing through his/her nose	<input type="checkbox"/> Yes	Age of diagnosis:
Sinus problems	<input type="checkbox"/> Yes	Age of diagnosis:
Chronic bronchitis or cough	<input type="checkbox"/> Yes	Age of diagnosis:
Allergies	<input type="checkbox"/> Yes	Age of diagnosis: Allergic to what:
Asthma	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent colds or flu's	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent ear infections	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent strep throat infections	<input type="checkbox"/> Yes	Age of diagnosis:
Difficulty swallowing	<input type="checkbox"/> Yes	Age of diagnosis:
Acid reflux (gastro esophageal reflux)	<input type="checkbox"/> Yes	Age of diagnosis:
Poor or delayed growth	<input type="checkbox"/> Yes	Age of diagnosis:
Excessive weight	<input type="checkbox"/> Yes	Age of diagnosis:
Hearing problems	<input type="checkbox"/> Yes	Age of diagnosis:
Speech problems	<input type="checkbox"/> Yes	Age of diagnosis:
Vision problems	<input type="checkbox"/> Yes	Age of diagnosis:
Seizures/Epilepsy	<input type="checkbox"/> Yes	Age of diagnosis:
Morning headaches	<input type="checkbox"/> Yes	Age of diagnosis:
Cerebral palsy	<input type="checkbox"/> Yes	Age of diagnosis:
Heart disease	<input type="checkbox"/> Yes	Age of diagnosis:
High blood pressure	<input type="checkbox"/> Yes	Age of diagnosis:
Sickle cell disease	<input type="checkbox"/> Yes	Age of diagnosis:
Genetic disease	<input type="checkbox"/> Yes	Age of diagnosis:
Chromosome problem (e.g., Down's Syndrome)	<input type="checkbox"/> Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	<input type="checkbox"/> Yes	Age of diagnosis:
Craniofacial disorder (e.g., Pierre-Robin)	<input type="checkbox"/> Yes	Age of diagnosis:
Thyroid problems	<input type="checkbox"/> Yes	Age of diagnosis:
Eczema (itchy skin)	<input type="checkbox"/> Yes	Age of diagnosis:
Chiari Malformation/Spina Bifida	<input type="checkbox"/> Yes	Age of diagnosis:
Pain	<input type="checkbox"/> Yes	Age of diagnosis:

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY		
Autism	<input type="checkbox"/> Yes	Age of diagnosis:
Developmental delay	<input type="checkbox"/> Yes	Age of diagnosis:
Hyperactivity/ADHD	<input type="checkbox"/> Yes	Age of diagnosis:
Anxiety/Panic Attacks	<input type="checkbox"/> Yes	Age of diagnosis:
Obsessive Compulsive Disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Depression	<input type="checkbox"/> Yes	Age of diagnosis:
Suicide	<input type="checkbox"/> Yes	Age of diagnosis:
Learning disability	<input type="checkbox"/> Yes	Age of diagnosis:
Drug use/abuse	<input type="checkbox"/> Yes	Age of diagnosis:
Behavioral disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Psychiatric Admission	<input type="checkbox"/> 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? No Yes Amount per day: _____
(e.g., Coke, Pepsi, Mountain Dew, Iced Tea)

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: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried		
Education:			Education		
Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time			Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time		
Occupation:			Occupation:		
PERSONS LIVING IN HOME					
Name:		Relationship:		Age:	

FAMILY SLEEP HISTORY				
Does anyone in the family have a sleep disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, mark the disorder(s):				
Insomnia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Snoring	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Sleep apnea	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Restless legs syndrome	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Periodic limb movement disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Sleepwalking/sleep terrors	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Sleep talking	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Narcolepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Bed-wetting	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Thyroid disturbance	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
High blood pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Anxiety disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent

FAMILY SLEEP HISTORY CONTINUED

Depression	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Other psychiatric disturbances	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Obesity	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> Grandparent
Other: _____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/Sister	<input type="checkbox"/> 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 few days 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: