

Child Sleep Questionnaire

Child's Name: _____ Address: _____

Date of Birth: _____ Telephone Number: _____ Gender: **M** **F** Neck Measurement: _____

Ethnic Background: _____

Medical Problems: _____

Medications (Prescription and over the counter): _____

Allergies: _____ Birth Weight: _____

Adenoids and tonsils removed: **Y N** Vision Problems: **Y N** Hearing Problems: **Y N** Poor appetite: **Y N**

Poor growth: **Y N** Ear infections: **Y N** Asthma: **Y N** Frequent Colds/flu: **Y N** Constant runny nose: **Y N**

Does your **child sleep alone**, share with 1, share with 2, share with 3, share with >3 Do any of his/her siblings snore? **Y N**

Does your child have ADHD (also called hyperkinetic/attention deficit)? **Y N** Is your child hyperactive? **Y N**

Is your child on any ADHD medication? **Y N**; Which one: _____

How long does your child sleep at night? _____ What time does your child go to bed? _____ What time does your child wake up? _____

The following questions can be answered by 1-“never”, 2-“rarely”, 3-“occasionally”, 4-“frequently”, 5-“almost always”.

Have you seen or heard your child having nightmares that he/she doesn't remember the next day?	1	2	3	4	5
Has he/she expressed fear of sleeping in the dark?	1	2	3	4	5
Is your child easy to wake up in the morning?	1	2	3	4	5
Does your child go to bed willingly?	1	2	3	4	5
Is he/she a restless sleeper?	1	2	3	4	5
Have you seen your child smiling during sleep?	1	2	3	4	5
Does he/she wake up at night?	1	2	3	4	5
Have you heard your child talking during his/her sleep?	1	2	3	4	5
Have you observed him/her sleepwalking?	1	2	3	4	5
While asleep, does he/she ever sit up in bed?	1	2	3	4	5
Does he/she grind his/her teeth during sleep?	1	2	3	4	5
Have you heard your child laugh during sleep?	1	2	3	4	5
Has your child told you about having a frightening dream?	1	2	3	4	5
Have you observed repetitive actions such as rocking or head banging during sleep?	1	2	3	4	5
Does he/she have problems with bed-wetting?	1	2	3	4	5
Have you observed your child having a nightmare during which he/she appeared extremely afraid or terrified?	1	2	3	4	5
Have you look in on your child and discovered he/she was crying while asleep?	1	2	3	4	5
Has he/she told you about having a pleasant dream?	1	2	3	4	5
Does your child complain about difficulties going to sleep?	1	2	3	4	5
Does your child get up to go to the bathroom during the night?	1	2	3	4	5
Does your child stop breathing during sleep?	1	2	3	4	5
Does your child struggle to breathe while asleep?	1	2	3	4	5
Does your child fall asleep easily?	1	2	3	4	5
Do you ever shake your child to make him/her breathe again when asleep?	1	2	3	4	5

Do your child's lips ever turn blue or purple while asleep?	1	2	3	4	5
Are you ever concerned about your child's breathing during sleep?	1	2	3	4	5
How often does your child snore?	1	2	3	4	5
How loud is the snore? (Responses to this question are <i>1 mildly quiet, 2 medium loud, 3 loud, 4 very loud, 5 extremely loud</i>)	1	2	3	4	5
How often does your child have a sore throat?	1	2	3	4	5
Does your child complain of morning headaches?	1	2	3	4	5
Is your child a daytime mouth breather?	1	2	3	4	5
Is your child sleepy during the daytime?	1	2	3	4	5
Does your child fall asleep at school?	1	2	3	4	5
Does your child fall asleep while watching television?	1	2	3	4	5

Pregnancy: **Normal** **Abnormal** Pregnancy: **Full-term** **Preterm** Infant Feeding: **Breast** **Bottle** Age weaned: _____

Father's job: _____

Snore: Y N Smoke: Y N

Mother's job: _____

Snore: Y N Smoke: Y N

Comments: