LITTLETON REGIONAL HEALTHCARE

North Country Sleep Center
580 St. Johnsbury Road, Suite C
Littleton, NH 03561
Ph:(603) 259-7780 Fax: (603)259-7778

Pediatric Sleep Evaluation Questionnaire

Today's Date: ___/___/_____

Demographic Information:

Child's Name: ______________________________ Date of Birth: ___/___/_____ Gender: ☐ M ☐ F

Parent Name: ____

Parent Phone: Home _________________ Work_________________ Cell _____________________

Primary Care Physician:___________________________________

Sleep Problems:

What are your major concerns about your child's sleep? ____

____

____

____

What have you previously tried to help this problem? ____

____

____

____

What does your child do in the hour before bed?

____

____

Sleep Schedule:

Weekdays:

Usual Bedtime: _________________ Usual Wake Time: ________________

Total estimated amount of sleep on weekdays (including naps): ________________________________

Weekends:

Usual Bedtime: ________________ Usual Wake Time: ________________

Total estimated amount of sleep on weekend days (including naps): ____________________________

Naps:

Number of days each week that the child naps: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Nap Times (from when to when): ____

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General Sleep Information:

	Yes	No
Does the child have a bedtime routine?	☐	☐
Does the child have his/her own bedroom?	☐	☐
Does the child have his/her own bed?	☐	☐
Does the child resist going to bed?	☐	☐
Does the child have difficulty falling asleep?	☐	☐
Does the child awaken during the night?	☐	☐
After a nighttime awakening, does the child have difficulty going back to sleep?	☐	☐
Is the child difficult to awaken in the morning?	☐	☐
Do you feel like the child is a poor sleeper?	☐	☐

How long does the child spend in his/her room before falling asleep?

Child usually falls asleep in:	Child sleeps most of the night in:	Child usually awakens in the morning in:
☐ own room in own bed	☐ own room in own bed	☐ own room in own bed
☐ parent's room/bed	☐ parent's room/bed	☐ parent's room/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

Current Sleep Symptoms:

	Never	Occasionally	Frequently
Snoring?	☐	☐	☐
Difficulty breathing during sleep?	☐	☐	☐
Stops breathing during sleep?	☐	☐	☐
Restless sleep?	☐	☐	☐
Sweating when sleeping?	☐	☐	☐
Nightmares?	☐	☐	☐
Sleepwalking?	☐	☐	☐
Sleep talking?	☐	☐	☐
Screaming during sleep?	☐	☐	☐
Legs kicking during sleep?	☐	☐	☐
Teeth grinding?	☐	☐	☐
Uncomfortable "creepy-crawly" feeling in the legs	☐	☐	☐
Bedwetting?	☐	☐	☐

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Current Daytime Symptoms:

	Never	Occasionally	Frequently
Wake up spontaneously?	☐	☐	☐
Have trouble getting up in the morning?	☐	☐	☐
Daytime sleepiness?	☐	☐	☐
Falls asleep at school?	☐	☐	☐
Naps after school?	☐	☐	☐
Feels weak or loses control of muscles with strong emotions?	☐	☐	☐
Reports being unable to move when falling asleep/waking up?	☐	☐	☐
Reports frightening visual images when falling asleep or waking up?	☐	☐	☐
Morning headaches?	☐	☐	☐
Poor appetite?	☐	☐	☐
Behavior problems?	☐	☐	☐

Does your child drink caffeinated beverages ☐ Yes ☐ No If yes, amount per day: ____________

School Performance:

Your child's grade __________

Has your child ever repeated a grade? ☐ Yes ☐ No If so, which grade?___

Is your child enrolled in any special education classes? ☐ Yes ☐ No

Child's grades: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Birth History:

Pregnancy: ☐ Normal ☐ Difficult

Delivery: ☐ Term ☐ Premature ☐ Post-term

Birth Weight: ______________

Is he/she an only child? ☐ Yes ☐ No If no, what number child is this? _______

Past Surgical History:

Has your child had his/her tonsils removed? ☐ Yes ☐ No At what age? ______

Has your child had his/her adenoids removed? ☐ Yes ☐ No At what age? ______

Has your child ever had ear tubes? ☐ Yes ☐ No At what age? ______

Other surgeries: ____

Has your child had orthodontic work/ braces? ☐ Yes ☐ No At what age? _______

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Family Information/History:

Mother: Age: ____ Occupation: ________________

Father: Age: ____ Occupation: ________________

Other people living in the house: ____

Does anyone in the family have a sleep disorder? ☐ Yes ☐ No

If yes, who and what disorder? ____

Do you have any other information that you would like to add?______________________

____

Epworth Sleepiness Scale—Children

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0=would never doze or sleep
1=slight chance of dozing or sleeping
2=moderate chance of dozing or sleeping
3=high chance of dozing or sleeping.

Circle the most appropriate number for each situation:

1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (movie, theater or classroom)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances Permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch	0	1	2	3
8. Doing homework or taking a test	0	1	2	3

TOTAL ____________________