Pediatric Sleep Medicine Services

Please complete this questionnaire and return it to the physician who interviews you and your child at the time of the **Initial Evaluation**.

Please be aware that after the initial consultation, your child may require follow up visits, sleep study(s), and sleep therapy.

In answering the questions be as complete as possible. The more information that is given the more complete will be the evaluation of your child's condition.

Use the back of the previous page to complete detailed answers or to add additional information, which is relevant.

Circle the most appropriate answers in the questionnaire.

DK = Means Don't Know **NA = Means Not Applicable**

The Sleep Medicine Center physician will go over the answers with you. We look forward to being able to evaluate your child's problem and to be able to provide therapeutic advice.

Please include your referring physician with contact information

Practice Name: _____
Dr. Name: _____
Address: _____
Phone: _____
Fax: _____

CHICAGO SLEEP GROUP **Patient's Name**_____
Sleep Clinic Patient Questionnaire **D.O.B**._____

1. Problem _____

   _____

2. When was the very first time this problem began? _____ years ago

3. List any medications that your child is currently taking to help with the sleep problem:
   Preparation Dose Time
   _____

   _____

   _____

4. Describe what your child usually does during the last 30 minutes before bedtime:

   _____

   _____

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

   Read Yes/No

   Watch TV Yes/No

   Listen to the Radio Yes/No

   Other:_____

6. Will your child fall asleep alone in bed? Yes/No
7. In order to sleep, does your child often need a special toy or object? Yes/No

   If so, describe:_____
8. Does your child often need a bottle in order to go to sleep? Yes/No
9. What type of bed does your child sleep in? Crib/Single Bed/Double Bed/other
10. Does your child sleep alone? Yes/No

    If so, who with? _____
11. Which side of the body does your child sleep on?

    Left side Right side Back Face down
12. What time is the bedroom light turned off: _____a.m./p.m.
13. Does a parent or the child turn off the light? Parent/child
14. Is your child bothered by environmental noises at night? Yes/No

    If so, please explain:_____
15. As an infant, was your child "colicky"? Yes/No

16. As an infant, did your child require any of the following devices to get to sleep?

Swing Snuggle Car Ride Being Held Other: _____

17. On average how long does it take your child to fall asleep? _____

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

_____hours _____minutes

19. What is the longest time it has taken your child to fall asleep?

_____hours _____minutes

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

Fears Loneliness Not Sleepy Worries Other: _____

21. Do you get annoyed/angry when your child cannot sleep? Yes/No

22. How often does your child cry him/herself to sleep? _____times per week

23. Do you ever let your child cry in bed in order to get to sleep? Yes/No

If so, how long do you let the child cry: 10/20/30 minutes/as long as it takes

24. When unable to fall asleep, does your child get out of bed? Yes/No

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

_____

26. How long is your child up for? _____ hours _____ minutes

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

_____ hours _____ minutes

28. If the child does not get out of bed, how long does it take to fall back to sleep?

_____ hours _____ minutes

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

_____ hours _____ minutes

30. Does your child awaken during the night? Yes/No

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

31. How often does your child awaken during the night? _____ times

32. What time does your child finally awaken in the morning? _____ a.m.

33. What time does your child get out of bed in the morning? _____a.m.

34. How does your child seem on awakening in the morning? _____

_____

_____

35. How does a poor nights sleep affect your child the next day? _____

_____

36. Does your child feel sleepy during the day? Yes/No
37. Does your child nap during the day? Yes/No

    If so, how often and for how long? _____ hours _____ minutes
38. What time of day does your child nap? _____ a.m. _____ p.m.
39. If there are no naps, what time of day does your child feel most tired? _____
40. What time of day does your child seem most alert? _____ a.m. _____ p.m.
41. As the sleep period approaches, does your child become more alert? Yes/No
42. Do you think a poor night's sleep effects your child's school performances the next day? Yes/No
43. Has the teacher commented on this? Yes/No
44. Does your child toss and turn in bed? Yes/No
45. Have you ever noticed your child's head rocking from side to side at night? Yes/No If so, please describe _____

    _____
46. How often does this behavior occur? _____ times
47. What time of night is this activity likely to occur? _____ a.m./p.m.
48. Does your child complain of aching legs at bedtime? Yes/No
49. Does your child move his/her legs around in bed at night? Yes/No
50. Does your child's legs jerk while he/she is asleep at night? Yes/No
51. Does your child have nightmares? Yes/No

    If so, at what age did they begin? ____ years How often do they occur? _____ times/night
52. Does your child ever awaken suddenly with a scream and appear inconsolable? Yes/No/DK

    If so, how often? _____ times/month
53. Does your child sleepwalk? Yes/No How often? _____times /week
54. If your child sleepwalks, has he/she ever injured himself? Yes/No
55. Does your child ever wet the bed? Yes/No If so, how often? _____ times/week
56. Does your child snore at night? Yes/No
57. Does the snoring occur every night? Yes/No

    If not, how often does it occur? _____ times/week

58. Does your child ever seem to stop breathing while asleep? Yes/No
    If so, for how long? _____ seconds
59. Has your child ever had a tonsillectomy or adenoidectomy? Yes/No
    If so, please give date _____
60. Please state when your child was last able to sleep consistently without any problems:
    Never/_____ years/months ago
61. What time did your child then go to bed? _____ a.m./p.m.
62. Did your child awaken during the night? Yes/No
    If so, how often and for how long? _____ times_____ minutes
63. What time did your child awaken in the morning? _____ a.m.
64. At what time would you like your child to fall asleep now? _____ p.m.
65. How long would you like your child to sleep for? _____ hours
66. What time would you like your child to awaken in the morning? _____ a.m.
67. For how long do you think normal children of your child's age sleep? _____ hours
68. Do you consider your child's sleep problem to be:
    Mild / Moderate / Severe
69. Please add any other comments about your child's sleep problem that you think are relevant:

    _____

    _____

    _____

    _____

70. Please list all people whom you have consulted about your child's sleep problem. Starting with the first, list the date, name, degree, specialty, investigations, treatment and outcomes of all treatments. (give details of medications on the next page).

    Date Name Degree Investigation Treatment