Prana Health
Ad Vitam - For Life

SLEEP QUESTIONNAIRE- PEDIATRIC

Child's Name: _____ Date: _____

Date of Birth: _____ Referring Physician: _____

Current Height: _____ Current Weight: _____

CHIEF COMPLAINT (WHAT SLEEP SYMPTOMS PROMPTED THIS EVALUATION)

☐ Diagnosis and treatment of sleep apnea
☐ Difficulty Staying awake during the day
☐ Abnormal behaviors during sleep
☐ Snoring
☐ Difficulty putting the child to sleep
☐ Other (Please describe):

INSTRUCTIONS

PLEASE ANSWER THE QUESTIONS ON THE FOLLOWING PAGES REGARDING THE BEHAVIOR OF YOUR CHILD DURING SLEEP AND WAKEFULNESS. THE QUESTIONS APPLY TO HOW YOUR CHILD ACTS IN GENERAL, NOT NECESSARILY DURING THE PAST FEW DAYS. YOU CHECK THE CORRECT RESPONSE OR PRINT YOUR ANSWERS NEATLY IN THE SPACE PROVIDED.

How long has the child had current sleep problem? _____
Have the child had a prior sleep study? ☐No ☐ Yes When_____ Where_____
Has the child had his/her tonsils removed? ☐ No ☐ Yes ☐ Don't Know

NIGHT TIME SYMPTOMS: Please check all which apply
☐ The child snores? If the child snores, is it: ☐ Mild ☐ Moderate ☐ Loud ☐ Very Loud
If yes, is it ☐ Every Night ☐ Usually ☐ Sometimes ☐ Don't Know
What worsens the snoring_____ What relieves it _____
☐ The child stops breathing while sleeping
☐ The child "struggle" to breathe while sleeping
☐ The child has "loud breathing" while sleeping
☐ The child has snorting or gasping episodes while sleeping
☐ The child breathe through mouth while sleeping
☐ The child sleeps in abnormal positions- Please describe_____
☐ Bedwetting ☐ Nasal Congestion ☐ Drooling of saliva on pillows
☐ **Abnormal movements/behaviors at night:**
- ☐ Head banging or rocking motions prior to falling asleep
- ☐ Excessive leg jerking during sleep
- ☐ Sleep walking ☐ acting out dreams ☐ Sleep talking ☐ Seizures
- ☐ Lip smacking

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Child's name_____ **DOB**_____

☐ **Abnormal movements/behaviors at night: continued**

☐ Unusual mouth movements ☐ grinding teeth ☐ Eating at night while awake
☐ Eating in sleep ☐ Other behavior or activity (please describe):

_____

☐ Uncomfortable sensations, "Ooees" "Owees" or "growing pains" in legs **prior to bedtime** relieved by moving them

SYMPTOMS OF NARCOLEPSY:

☐ Does the child ever feel weak (knees buckle) when emotional (anger, surprise, laughing. If so , how often_____
☐ Vivid dreams or images or hallucinations just when the child is falling asleep or waking up from sleep. If so how often_____
☐ Unable to move and feeling paralyzed just as the child is falling asleep or is waking up form sleep. If so, how often_____

DAYTIME SYMPTOMS: Please check all those apply

☐ The child has poor sleep and feels ☐ Tired ☐Sleepy ☐Groggy ☐Exhausted
☐ The child wake up with a headache
☐ The child wake up with a dry mouth
☐ The child has trouble at school because of sleepiness
☐ The child gets late to school frequently
☐ The child has trouble concentrating
☐ The child has hyperactivity
☐ The child's grades are declining
☐ The child has behavioral problems

SLEEP PATTERN

What is the child's usual bedtime? _____ usual rise time? _____
On average, how long does it take for the child to fall asleep?
☐ The child have unusual or "difficult routine" or "rituals" at bedtime, argumentative or behaves badly before going to bed
☐ On average, how many hours does the child actually sleep at night_____

PAST MEDICAL HISTORY

☐ Delayed developmental ☐ Problems sleeping during infancy and early childhood
Medical Illness:

☐ High blood pressure ☐ ADHD ☐ Allergies ☐ Depression ☐ Anxiety☐ Acid reflux ☐ Head Injury ☐ Seizures ☐ Iron deficiency ☐ Others: _____

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Surgical history: List all surgeries that the child has had and approximate dates if possible:

1. _____
2. _____
3. _____

ALLERGIES:_____

MEDICATION HISTORY: Please list all medications that the child is currently taking,

Drug	Dosage	Times per day	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pediatric Epworth Sleepiness Scale (ESS)

How LIKELY is the child likely to DOZE OFF or FALL ASLEEP in the following situations, in contrast to feeling tired? This refers to the child's usual way of life in recent times (within the last 6 months or last year). Even if the child has not done some of these things recently, try to work out how they would have affected the child.

0 = Would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Situation	**Chance of Dozing**
Sitting and reading……	0 1 2 3
Watching TV……	0 1 2 3
Sitting inactive in a public place (i.e. theater or meeting)……	0 1 2 3
As a passenger in a car without a break……	0 1 2 3
Lying down in the afternoon when circumstances permit……	0 1 2 3
Sitting and talking to someone……	0 1 2 3
Sitting quietly after lunch ……	0 1 2 3
Playing Video games……	0 1 2 3
TOTAL	_____

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FAMILY HISTORY

Check all that applies ☐ Sleep apnea ☐ Restless legs syndrome ☐ Narcolepsy ☐ major illnesses in parents and siblings (please describe)

_____

SOCIAL HISTORY

☐ Living with parent (s):
☐ The child has sibling (s) (how many)_____
☐ Special education program
☐ Smoking ☐ Alcohol ☐ Recreational drug
What grade:_____

REVIEW OF SYSTEMS: (PLEASE CHECK ALL THAT APPLY TO YOU):

General:	☐Weight Loss	☐Weight Gain	☐Night Sweats
Eyes:	☐Decreased vision	☐Double Vision	☐Wears Glasses
CVS:	☐Chest pain	☐Palpitation/ irregular heart beat	
	☐Murmur	☐Leg Swelling	
Respiratory:	☐Chronic Cough	☐Short of breath	☐Wheezing/Asthma
GI:	☐Constipation	☐Colic	
GU:	☐Bedwetting	☐Frequent urination at night	
MSK:	☐Joint Pains		
Skin:	☐Easily bruised	☐Rash	
Neuro:	☐Weakness	☐Numbness	☐Headaches
Psychiatric:	☐Anxiety	☐Depression	
Endocrine:	☐Thyroid disease	☐Diabetes	☐Precocious puberty
Heme:	☐Anemia	☐ Bleeding tendency	
Ears:	☐Decreased hearing	☐Ear Infections	☐Ringing in the ears
Aller/ Immu:	☐Seasonal allergies	☐Contact dermatitis with Neoprene	

Nose: ☐ Nasal Congestion/discharge/bleeding ☐ Nasal blockage

☐ Facial Pain/fullness/pressure ☐ Loss of sense of smell

GIRLS ONLY: ☐Irregular periods ☐Pregnant ☐Using contraceptives *(some medications used in treating sleep disorders can impair the effectiveness of certain contraceptives)*

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Child's Name:_____ DOB_____

DEPRESSION SCREEN (ONLY FOR CHILDREN> 12 years old)

1. **Over the *last 2 weeks,* how often have you been bothered by any of the following problems?**

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching tv.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

ADD COLUMNS: _____ + _____ + _____ + _____

TOTAL: _____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the las 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the day	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	_____	_____	_____	____

Total Score =_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all_____
Somewhat difficult_____
Very difficult_____
Extremely difficult_____