Pacific Sleep Program

Portland & Astoria

Setting the standard in sleep medicine for over 35 years

PEDIATRIC SLEEP EVALUATION QUESTIONNAIRE

Please complete this questionnaire by choosing or filling in the answer that best fits your child.

- If the child cannot directly answer a question, please provide an estimate based on your own observations.
- For older children and teens, it might be best to fill out the questionnaire together.
- These questions span children of many ages; if a question appears inappropriate for your child's age, please just ignore it.
- We know that the parenting role can comprise many different people. Please assume that the word "parent" includes foster parents, legal guardians, grandparents and other family members, and anyone else in a parenting role.

GENERAL INFORMATION

Child's name:	Child's gender: ☐ Male ☐ Female ☐ Non-binary
Child's birthdate: ___ / ___ / _____	Child's age:

THE EPWORTH SLEEPINESS SCALE

How likely is the child to doze off or fall asleep in the following situations? Even if the child has not done some of these things recently, give your best estimate for each situation, using the scale below. If the child is too young to respond directly, please choose a response based on what you've observed. When you've completed the table, add all the scores and fill in the total.

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

	Chance of dozing (0–3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g., a theater or a classroom)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon if they are able	
Sitting and talking to someone	
Sitting quietly after lunch	
Doing homework or taking a test	

Total score: _____

SLEEP CONCERNS

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

Has the child previously had a sleep study? ☐ Yes ☐ No

If **Yes**, when and where? _____

SCHOOL PERFORMANCE

Complete this section only if the child is school-age.

Child's grade: _____ Has the child ever repeated a grade? ☐ No ☐ Yes

Is the child homeschooled? ☐ No ☐ Yes

Does the child receive any special education services? ☐ No ☐ Yes

If **Yes**, please describe: _____

_____

Has the child ever missed or been late to school due to sleep issues? ☐ No ☐ Yes

If **Yes**, how often? _____

Has the child ever fallen asleep in school? ☐ No ☐ Yes

If **Yes**, how often? _____

How are the child's grades this year?

☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Does the child have any difficulties with school performance (e.g., paying attention, concentrating) or any behavioral issues (e.g., hyperactivity)? ☐ No ☐ Yes

If **Yes**, please tell us about them:

Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician or a psychologist, **or any concerns the child's teachers have expressed**.

SLEEP HISTORY

WEEKDAY SLEEP SCHEDULE

What is the child's usual bedtime on **weekday nights**? _____:_____ p.m.

What is the child's usual waking time on **weekday mornings**? _____:_____ a.m.

How long does it usually take the child to fall asleep on **weekdays**? _____

Add the child's daytime and nighttime sleep hours. How much does the child sleep during a typical 24-hour period on **weekdays**? _____ hours

WEEKEND AND VACATION SLEEP SCHEDULE

What is the child's usual bedtime on **weekend/vacation nights**: _____:_____ p.m.

What is the child's usual waking time on **weekend/vacation mornings**: _____:_____ a.m.

How long does it take the child to fall asleep on **weekend/vacation nights**? _____

Add the child's daytime and nighttime sleep hours. How much does the child sleep during a typical 24-hour period **on weekends and vacations**? _____ hours

NAP SCHEDULE

Complete this section only if the child takes naps.

How many **days each week** does the child take a nap?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

What are the child's usual nap times?

Nap 1: ____ : ____ ☐ a.m. ☐ p.m. to ____ : ____ ☐ a.m. ☐ p.m.

Nap 2: ____ : ____ ☐ a.m. ☐ p.m. to ____ : ____ ☐ a.m. ☐ p.m.

From what you've observed, are the child's naps refreshing? ☐ No ☐ Yes

GENERAL SLEEP

Does the child currently take, or have they taken in the past, any prescribed or over-the-counter medications (including melatonin) for sleep? ☐ Yes ☐ No

If **Yes**, which medications, what dose, and for how long? _____

_____

If **Yes**, was the medication effective? ☐ Yes ☐ No

Does the child have difficulty falling asleep? ☐ Yes ☐ No

If **Yes**, for how long? _____ minutes / hours (circle one)

SLEEP HISTORY (CONT.)

GENERAL SLEEP (CONT.)

Does the child awaken during the night? ☐ Yes ☐ No

If **Yes**, how many times? _____

After waking at night, does the child have difficulty falling back to sleep? ☐ Yes ☐ No

If **Yes**, for how long? _____ minutes / hours (circle one)

Is the child difficult to awaken in the morning? ☐ Yes ☐ No

If **Yes**, do you think this is a problem? ☐ Yes ☐ No

Does the child resist going to bed? ☐ Yes ☐ No

If **Yes**, do you think this is a problem? ☐ Yes ☐ No

Does the child have a regular bedtime routine? ☐ Yes ☐ No

Does the child watch TV or use electronic devices (computer, tablets, phones, etc.) before bed? ☐ Yes ☐ No

If **Yes**, how close to bedtime? _____ minutes / hours (circle one)

Does the child have their own bedroom? ☐ Yes ☐ No, shares with _____

Is the child's sleeping area cool, dark, and quiet? ☐ Yes ☐ No

Is the child bothered by outside lights, noise, people, and/or animals when trying to sleep? ☐ Yes ☐ No

Who usually puts the child to bed? ☐ Mother ☐ Father ☐ Both parents

☐ Child does it themselves ☐ Other: _____

Is a parent present when the child falls asleep? ☐ Yes ☐ No

Does the child fall asleep in their own bed? ☐ Yes ☐ No

Does the child sleep most of the night in their own bed? ☐ Yes ☐ No

When the child is awake at night, do they complain of their mind racing or being worried or scared? ☐ Yes ☐ No

In which of the following positions does the child sleep? Check all that apply:

☐ On their back ☐ On their sides ☐ On their stomach

☐ With their neck hyperextended ☐ Elevated on pillows

CURRENT SLEEP SYMPTOMS

Use the scale below to give your best estimate for each situation. If the child is too young to respond directly, please choose a response based on what you've observed.

a: Never (does not happen)
b: Not often (less than 1 night/day per week)
c: Sometimes (1 to 2 nights/days per week)
d: Often (3 to 5 nights/days per week)
e: Almost always (6 to 7 nights/days per week)
f: I do not know

Does the child ever:

1.	Snore	__ a	__ b	__ c	__ d	__ e	__ f
2.	Stop breathing during sleep	__ a	__ b	__ c	__ d	__ e	__ f
3.	Choke or gasp at night	__ a	__ b	__ c	__ d	__ e	__ f
4.	Breathe mainly through their mouth at night or have noisy breathing	__ a	__ b	__ c	__ d	__ e	__ f
5.	Have significant nasal congestion at night	__ a	__ b	__ c	__ d	__ e	__ f
6.	Have known reflux at night or awaken with a bad taste in their mouth as if acid has come up	__ a	__ b	__ c	__ d	__ e	__ f
7.	Appear restless during sleep; toss and turn when asleep	__ a	__ b	__ c	__ d	__ e	__ f
8.	Sweat when sleeping	__ a	__ b	__ c	__ d	__ e	__ f
9.	Complain of a headache upon awakening	__ a	__ b	__ c	__ d	__ e	__ f
10.	Grind their teeth	__ a	__ b	__ c	__ d	__ e	__ f
11.	Wet the bed during sleep	__ a	__ b	__ c	__ d	__ e	__ f
12.	Kick their legs during sleep	__ a	__ b	__ c	__ d	__ e	__ f
13.	Report an uncomfortable feeling in their legs or a creepy-crawly feeling when they're trying to go to sleep	__ a	__ b	__ c	__ d	__ e	__ f
14.	Sleepwalk	__ a	__ b	__ c	__ d	__ e	__ f
15.	Talk in their sleep	__ a	__ b	__ c	__ d	__ e	__ f
16.	Have night terrors (episodes of screaming, intense fear, and flailing while still asleep and is inconsolable afterward)	__ a	__ b	__ c	__ d	__ e	__ f
17.	Have frequent nightmares	__ a	__ b	__ c	__ d	__ e	__ f
18.	Feel weak or lose control of their muscles after exhibiting strong emotions	__ a	__ b	__ c	__ d	__ e	__ f
19.	Report being unable to move when falling asleep or upon waking	__ a	__ b	__ c	__ d	__ e	__ f
20.	Report seeing frightening visual images before falling asleep or upon waking	__ a	__ b	__ c	__ d	__ e	__ f

MEDICAL AND PSYCHIATRIC HISTORY

PAST MEDICAL HISTORY

Does the child have a history of any of the following:

Enlarged tonsils or adenoids?	☐ No ☐ Yes	If **Yes**, age of diagnosis: _____
Frequent colds or flus?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Frequent ear infections?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Frequent strep throat infections?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Difficulty swallowing?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Trouble breathing through their nose?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Sinus problems?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Chronic bronchitis or cough?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Allergies?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
If **Yes**, what is the child allergic to?	_____	
Asthma?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Acid reflux (gastroesophageal reflux)?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Poor or delayed growth?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Excessive weight?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Hearing problems?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Speech problems?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Vision problems?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Seizures or epilepsy?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Headaches?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Cerebral palsy?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Heart disease?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
High blood pressure?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Sickle cell disease?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Genetic disease?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Chromosome problems (e.g., Down's)?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Skeleton problem (e.g., dwarfism)?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Craniofacial disorder (e.g., Pierre-Robin)?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Thyroid problems?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Eczema (itchy skin)?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____
Chronic pain?	☐ No ☐ Yes	If **Yes**, age of diagnosis:_____

MEDICAL AND PSYCHIATRIC HISTORY (CONT.)

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Does the child have a history of any of the following:

Hyperactivity or ADHD? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

Anxiety or panic attacks? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

Depression? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

Obsessive-compulsive disorder? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

History of suicidal thoughts or attempted suicide? ☐ No ☐ Yes

If **Yes**, please describe: _____

Alcohol or other drug misuse? ☐ No ☐ Yes

If **Yes**, please describe: _____

Autism? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

Developmental disability? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

Learning disability? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

Behavioral disorder? ☐ No ☐ Yes If **Yes**, age of diagnosis:_____

Psychiatric admission? ☐ No ☐ Yes

If **Yes**, please describe: _____

MOTHER'S PREGNANCY AND DELIVERY HISTORY

Was the child's delivery: ☐ To term ☐ Pre-term ☐ Post-term

Were either of the following required during the child's birth?

A stay in the NICU: ☐ Yes ☐ No Oxygen: ☐ Yes ☐ No

CURRENT MEDICAL HISTORY

Please list any medications the child currently takes:

Medicine	Dose	How often?

Is the child allergic to any medications? ☐ No ☐ Yes If **Yes**, please list them here:

Medical and Psychiatric History (cont.)

Surgeries and Hospitalizations

Has the child had their tonsils removed? ☐ No ☐ Yes If **Yes**, age of surgery: _____

Has the child had their adenoids removed? ☐ No ☐ Yes If **Yes**, age of surgery: _____

Has the child ever had ear tubes? ☐ No ☐ Yes If **Yes**, age of surgery: _____

Please list any additional hospitalizations or surgeries:

Health Habits

Does the child drink caffeinated beverages (e.g., Coke, Pepsi, Mountain Dew, iced tea, energy drinks)? ☐ Yes ☐ No

If **Yes**, how many does the child drink? _____ per day

How many hours per day of screen time (other than for school) does the child get? _____

How many hours per day of physical activity does the child get? _____

Are there any pets at home? ☐ Yes ☐ No

Is the child exposed to tobacco at home? ☐ Yes ☐ No

If **Yes**, how much tobacco is the child exposed to per day? _____

Family Information

Parent / Guardian 1:

Relationship to patient:

Parent / Guardian 2:

Relationship to patient:

Other Persons Living in the Home		
Name	**Relationship to Patient**	**Age**

FAMILY SLEEP HISTORY

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

If **Yes**, mark the relevant disorder below, and indicate which family member has it:

Insomnia:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Snoring:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep apnea:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Restless legs syndrome:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking or sleep terrors:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep talking:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other: _____	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent