Sleep Intake Questionnaire

Patient’s Name: ____________________________________________ Today’s Date: ___ / ___ / ___
Referring Physician: _________________________________________ Patient’s Date-of-Birth: ___ / ___ / ___
Primary Care Physician: ______________________________ Medical Record Number (MR#) _______________________

What sleep problem is your child having that you or your doctor are concerned about?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Person completing form: __________________________________________________ Relationship to patient: __________________________

Sleep Environment

1. Does your child have a set bedtime? □ Yes □ No
2. What time does your child usually:
   Go to bed on a weekday? _______ AM/PM       Go to bed on the weekend? _______ AM/PM
   Awaken in the morning on a weekday? _______ AM/PM  Awaken in the morning on the weekend? _______ AM/PM
3. What is your child’s usual bedtime ritual? (What does your child do prior to going to bed?) ___________________________________________
   ________________________________________________________________________________
4. In which room does your child usually sleep at night?
   □ His/her own bedroom □ Parent’s (your) bedroom □ Other room, please describe:
   □ Bedroom shared with sibling □ Family/Living room
5. Where does he/she sleep? (Check all that apply)
   □ Bed □ Sleeps in same bed with parent □ Floor
   □ Crib □ Couch □ Other, please describe:
   □ Sleeps in same bed with sibling □ Chair
6. Which of the following is in the room where your child sleeps? (Check all that apply)
   □ Television □ Music □ Computer
   □ Telephone □ Mobile phone □ Pet(s)
7. Does your child require special conditions in order to sleep at night? (Check all that may apply)
   □ No special conditions required □ Bedroom light on □ Other: ___________________________
   □ Cold temperature □ Open window
8. Does your child use any of the following during his/her sleep at night?
   □ No breathing support □ CPAP □ Other: ___________________________
   □ Oxygen □ BiPAP
9. How many pillows does your child usually sleep with?
   □ None □ Two □ Four or more
   □ One □ Three
10. Does your child feel safe in his/her sleeping environment? □ Yes □ No
11. Does your child sleep:
   With his/her neck hyperextended (lifted up in the air)? □ Never □ Some nights □ Most nights □ Every night
   With his/her bottom up in the air? □ Never □ Some nights □ Most nights □ Every night
   In a position you feel is unusual? □ Never □ Some nights □ Most nights □ Every night
   If your child sleeps in a position you feel is unusual, please describe: ___________________________________________
   ___________________________________________
Sleeping Problems

12. During the past 3 months, has your child experienced any of the following?

- Difficulty falling asleep
- Trouble staying asleep
- Restless sleeping (frequently moving about)
- Change in skin color, turns pale or blue
- Breathing during sleep interrupted by long pauses (10 or more seconds of absent/shallow breathing)
- Breathing during sleep interrupted by gasping or choking
- Sweating during sleep
- Jaw clenching
- Teeth grinding
- Mouth breathing
- Gets out of bed to urinate
- Wets the bed at night
- Crawling sensation in legs
- Nightmares
- Night Terrors
- Sleep talking
- Sleep walking

13. Have you had any treatments at home for any of these conditions?  □ Yes  □ No

If Yes, please explain: ____________________________________________________________

14. Do you ever have to wake your child up to help him/her breathe?  □ Yes  □ No

15. Does your child experience sleep problems at different times of the year?  □ Yes  □ No

If Yes, please explain: ____________________________________________________________

Snoring

16. Does your child snore at night?  □ Never  □ Some nights  □ Most nights  □ Every night

If your child snores at night, please describe the loudness of the snoring:

- My child does not snore
- Barely audible in room
- Easily heard in room, but not outside the bedroom
- Audible outside room
- Other: ____________________________________________________________

Awakening

17. In the morning, does your child experience any of the following?

- Awakens refreshed and rested
- Awakens tired and still sleepy after a full night’s sleep
- Awakens coughing
- Awakens choking
- Awakens with a headache
- Needs help to awaken

18. Does your child awaken with a problem other than those above?  □ Yes  □ No

If Yes, please explain: ____________________________________________________________
### Daytime Sleepiness

19. In the following situations, what is the chance your child would doze off or fall asleep?

<table>
<thead>
<tr>
<th>Situations</th>
<th>No</th>
<th>Slight</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
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<td>Sitting, inactive in a public place (e.g., theatre or meeting)</td>
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<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after a lunch</td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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Citation: Modified Epworth Sleepiness Scale from Melendres, Lutz, Rubin, Marcus. Pediatrics 2004; 114:768-775 based on the original Epworth Sleepiness Scale from Johns. Sleep 1991; 14:540-545

20. How often does your child have trouble staying awake throughout the entire day?          | Never | Sometimes | Often | Always |
21. How often does your child take a daytime nap?                                      | Never | Sometimes | Often | Always |
22. If your child does take a nap, how long is the nap?                                 | Does not nap | ½ hour or less | ½ hour-1 hour | 1-2 hours | >2 hours |
23. Has napping changed in the past two years?                                         | Yes | No |

24. Does your child experience his/her body sagging or becoming limp when upset (angry) or surprised? | Yes | No |
25. Does your child experience his / her head & neck becoming limp when angry?           | Yes | No |
26. Does your child experience his / her head & neck becoming limp when laughing?       | Yes | No |
27. Does your child fall asleep during the day even when trying to stay awake?          | Yes | No |
28. Does your child report having vivid (colorful) dreams or daydreams when falling asleep? | Yes | No |
29. Does your child report having vivid (colorful) dreams or daydreams when awakening from a nap or overnight sleep? | Yes | No |
30. Does your child report feeling paralyzed (unable to move) when falling asleep or when awakening from a nap or overnight sleep? | Yes | No |

### Overall Health

31. How is your child ‘s performance in school?          | Below grade level | At grade level | Above grade level | N/A |
32. Has your child’s performance changed in the past two years? | Yes | No |
   If Yes, please explain:________________________________________________________________________________________

33. Where does your child have behavioral problems?
   □ My child does not have behavioral problems
   □ In school
   □ With peers/playmates
   □ At home
   □ Other: __________________________________________________________________________________________

34. Does your child have any stress or anxiety due to a recent change at home or at school? | Yes | No |
   If Yes, please explain:________________________________________________________________________________________

35. Has there been any change in performance in sports in the past 3 months? | Yes | No |
36. Has your child missed any school days due to sleep problems? | Yes | No |
   If Yes, how many in the past 2 months? ____________
37. How often has your child been late for school due to sleep problems? | Never | Less than monthly | Monthly | At least weekly |

38. Does your child have: (Check all that may apply)
   □ Developmental delay  □ Frequent colds  □ Overweight  □ Fatigue/Tiredness  □ Depression
   □ Hyperactivity  □ Learning disabilities  □ Seasonal issues  □ Hay fever/allergies  □ Asthma
   □ Sad mood  □ Irritable mood  □ Difficulty concentrating  □ ADHD  □ Other: ________________
39. On a typical day, does your child drink any energy drinks or caffeinated beverages (cola, tea, coffee, Jolt® Mountain Dew®, Red Bull®, Monster®, ROCKSTAR Energy Drink®)?  □ Yes  □ No  If so how many cups or cans in a typical day? __________________________________________

40. Does anyone in the household smoke?  □ Yes  □ No  If so, please explain: ___________________________________________________________

41. Does anyone in the household use cigarettes, smokeless tobacco, snuff, or other tobacco products?  □ Yes  □ No  □ N/A  If so, which ones and how often? _______________________________________________________

42. Does your child use any recreational drugs that you know of?  □ Yes  □ No  □ N/A  If so, which ones and how often? _______________________________________________________

Medications

43. Does your child take any of the following?

- Prescription medications  □ Yes  □ No
- Over-the-counter medications  □ Yes  □ No
- Herbal Remedies or Nutritional Supplements  □ Yes  □ No

If Yes, please list below:

<table>
<thead>
<tr>
<th>Prescription Medication Name</th>
<th>How much?</th>
<th>How often?</th>
<th>Last taken?</th>
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<table>
<thead>
<tr>
<th>Over-the-counter Medication Name</th>
<th>How much?</th>
<th>How often?</th>
<th>Last taken?</th>
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<tr>
<th>Herbal Remedy / Nutritional Supplement Name:</th>
<th>Last taken?</th>
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Thank you for sharing with us information about your family and child. This information will help our specialists diagnose health concerns, interpret your child’s sleep study and develop treatment plans.

Information Reviewed By: (Initials) ______________ Signature: ________________________________

Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CPAP</td>
<td>Continuous Positive Airway Pressure</td>
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<tr>
<td>ADHD</td>
<td>Attention-Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>BiPAP</td>
<td>Bilevel Positive Airway Pressure</td>
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<tr>
<td>N/A</td>
<td>Not applicable</td>
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<tr>
<td>MR#</td>
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