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 may 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 may 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: _____

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Sleeping Problems

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

Difficulty falling asleep	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Trouble staying asleep	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Restless sleeping (frequently moving about)	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Change in skin color, turns pale or blue	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Breathing during sleep interrupted by long pauses (10 or more seconds of absent/shallow breathing)	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Breathing during sleep interrupted by gasping or choking	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Sweating during sleep	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Jaw clenching	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Teeth grinding	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Mouth breathing	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Gets out of bed to urinate	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Wets the bed at night	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Crawling sensation in legs	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Nightmares	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Night Terrors	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Sleep talking	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know
Sleep walking	☐Never	☐Some nights	☐Most nights	☐Every night	☐Don't know

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	☐Never	☐Some mornings	☐Most mornings	☐Every morning
Awakens tired and still sleepy after a full night's sleep	☐Never	☐Some mornings	☐Most mornings	☐Every morning
Awakens coughing	☐Never	☐Some mornings	☐Most mornings	☐Every morning
Awakens choking	☐Never	☐Some mornings	☐Most mornings	☐Every morning
Awakens with a headache	☐Never	☐Some mornings	☐Most mornings	☐Every morning
Needs help to awaken	☐Never	☐Some mornings	☐Most mornings	☐Every morning

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

If Yes, please explain: _____

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Daytime Sleepiness

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

Sitting and reading	☐No	☐Slight	☐Moderate	☐High
Watching TV	☐No	☐Slight	☐Moderate	☐High
Sitting, inactive in a public place (e.g., theatre or meeting)	☐No	☐Slight	☐Moderate	☐High
As a passenger in a car for an hour without a break	☐No	☐Slight	☐Moderate	☐High
Lying down to rest in the afternoon when circumstances permit	☐No	☐Slight	☐Moderate	☐High
Sitting and talking to someone	☐No	☐Slight	☐Moderate	☐High
Sitting quietly after a lunch	☐No	☐Slight	☐Moderate	☐High
In a car, while stopped for a few minutes in traffic	☐No	☐Slight	☐Moderate	☐High

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 ☐Other: _____

☐With peers/playmates ☐At home _____

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:_____

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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:

Prescription Medication Name	How much?	How often?	Last taken?

Over-the-counter Medication Name	How much?	How often?	Last taken?

Herbal Remedy / Nutritional Supplement Name:	Last taken?

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

CPAP	Continuous Positive Airway Pressure	ADHD	Attention-Deficit Hyperactivity Disorder
ADHD	Attention-Deficit Hyperactivity Disorder	BiPAP	Bilevel Positive Airway Pressure
MR#	Medical Record number	N/A	Not applicable

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