

Today's Date: \_\_\_/\_\_\_/\_\_\_

**ADOLESCENT SLEEP HABITS SURVEY  
(PARENT VERSION)**

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1. Name of Patient: \_\_\_\_\_ 2. Date of Birth: \_\_\_/\_\_\_/\_\_\_

3. Name of person completing questionnaire \_\_\_\_\_

Relationship to child \_\_\_\_\_

Referred by \_\_\_\_\_

Pediatrician \_\_\_\_\_

4. A copy of the sleep clinic evaluation will be sent to you, your pediatrician, and any referring physician. Please indicate anyone else who should receive a copy:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

5. What are your major concerns about your adolescent's sleep? \_\_\_\_\_

6. What do you think is causing your adolescent's sleep problem? \_\_\_\_\_

7. When did your adolescent's sleep problems start? \_\_\_\_\_

**FAMILY INFORMATION**

8. Please list all members of the households in which your adolescent lives full or part-time:

<u>Name/Relationship to Adolescent</u>	<u>Age</u>	<u>Adolescent lives with (please indicate full-time or part-time)</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Mother's Marital Status: Married Divorced Separated Widowed Single

If divorced, adolescent custody with: \_\_\_\_\_

10. Mother's education: \_\_\_\_\_

11. Mother's occupation: \_\_\_\_\_

Does mother work outside of home?  yes  no

If yes, mark each label that best describes her work:

- |  |  |
|--|--|
| <input type="checkbox"/> day shift               | <input type="checkbox"/> full time         |
| <input type="checkbox"/> evening shift           | <input type="checkbox"/> part time         |
| <input type="checkbox"/> night shift (graveyard) | <input type="checkbox"/> one job           |
| <input type="checkbox"/> changing shifts         | <input type="checkbox"/> more than one job |

12. Father's Marital Status: Married Divorced Separated Widowed Single

If divorced, adolescent custody with: \_\_\_\_\_

13. What is father's education: \_\_\_\_\_

14. Father's occupation: \_\_\_\_\_

Does father work outside of home?  Yes  No

If yes, mark each label that best describes his work:

- day shift  full time
- evening shift  part time
- night shift (graveyard)  one job
- changing shifts  more than one job

15. What best describes your adolescent's racial/ethnic background?

- White/Caucasian \_\_\_\_\_ Asian/Asian American \_\_\_\_\_
- Black/African American \_\_\_\_\_ Native American \_\_\_\_\_
- Hispanic/Latino \_\_\_\_\_ Multiracial (Please specify) \_\_\_\_\_
- Other (Please specify) \_\_\_\_\_

16. Please list family members (parents, grandparents, siblings, aunts/uncles) with a history of any SLEEP PROBLEMS (including: loud snoring/obstructive sleep apnea, excessive sleepiness/narcolepsy, restless legs/periodic leg movements, insomnia, other sleep problems).

<u>Family Member</u>	<u>Type of Sleep Problem</u>

17. Has anyone in your family ever had a car accident caused by sleepiness (not due to alcohol or drugs)? Yes  No  Don't know

If yes, whom: \_\_\_\_\_ At what age: \_\_\_\_\_

Type of accident: \_\_\_\_\_

18. Please list any family members with a significant mental health condition (such as depression, anxiety, alcoholism/substance abuse).

<u>Family Member</u>	<u>Type of Mental Health Problem</u>

## SLEEP HISTORY (GENERAL)

19. What time does your adolescent usually go to bed on school nights? \_\_\_\_\_  
Range: \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm
20. What is the main reason your adolescent goes to bed at a particular time? (Check one below)
- \_\_\_\_\_ a. Because it fits best with the family's schedule
  - \_\_\_\_\_ b. Because she/he feels sleepy then
  - \_\_\_\_\_ c. Because that is when her/his TV shows are over
  - \_\_\_\_\_ d. Because that is when her/his brothers and sisters go to bed
  - \_\_\_\_\_ e. To "get enough sleep" for the following day's activities
  - \_\_\_\_\_ f. Other (describe briefly) \_\_\_\_\_
21. What time does your adolescent usually wake up on school day mornings? \_\_\_\_\_  
Range: \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm
22. What usually wakes up your adolescent in the morning on school days? (Check one below)
- \_\_\_\_\_ a. Alarm clock
  - \_\_\_\_\_ b. Parent or other family member
  - \_\_\_\_\_ c. Noise
  - \_\_\_\_\_ d. Needs to go to the bathroom
  - \_\_\_\_\_ e. Spontaneous
  - \_\_\_\_\_ f. Other (describe briefly):
23. Which of the following applies to waking your adolescent in the morning on school days? (Check one below)
- \_\_\_\_\_ a. I almost always have great difficulty getting him/her out of bed
  - \_\_\_\_\_ b. I sometimes have great difficulty getting him/her our of bed
  - \_\_\_\_\_ c. I seldom have great difficulty getting him/her out of bed
  - \_\_\_\_\_ d. I never have great difficulty getting him/her out of bed
24. What times does your adolescent usually go to bed on weekend nights? \_\_\_\_\_  
Range: \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm
25. What time does your adolescent usually wake up on weekend mornings? \_\_\_\_\_  
Range: \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm
26. What usually wakes up your adolescent in the morning on weekends? (Check one below)
- \_\_\_\_\_ a. Alarm clock
  - \_\_\_\_\_ b. Parent or other family member
  - \_\_\_\_\_ c. Noise
  - \_\_\_\_\_ d. Needs to go to the bathroom
  - \_\_\_\_\_ e. Spontaneous
  - \_\_\_\_\_ f. Other (describe briefly):
27. Which of the following applies to waking your adolescent in the morning on weekends? (Check one below)
- \_\_\_\_\_ a. I almost always have great difficulty getting him/her out of bed
  - \_\_\_\_\_ b. I sometimes have great difficulty getting him/her our of bed
  - \_\_\_\_\_ c. I seldom have great difficulty getting him/her out of bed
  - \_\_\_\_\_ d. I never have great difficulty getting him/her out of bed

28. IN AN AVERAGE TWO-WEEK PERIOD, HOW OFTEN DOES YOUR ADOLESCENT ..  
 (Check one answer for each question; please feel free to comment)

	Every day/ night	5-6 times	3-4 times	1-2 times	Never	Comments:
snore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
snore loudly and disruptively?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
sleep restlessly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
sleep in an abnormal position?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
sweat while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
pause in breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
complain of headache on waking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
sleepwalk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
sleeptalk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
cry out during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
wake up at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
get out of bed at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
complain about his/her sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
complain of pain at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
wet the bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

29. Has your adolescent ever used medication (over-the-counter or prescription) including herbal or “natural” remedies to help with sleep?

Yes  No  Don't know

If yes, name of medication and how frequently used: \_\_\_\_\_

30. Does your adolescent currently (within the past month) use medications (over-the-counter or prescription) to help with sleep? Yes  No  Don't know

If yes, name of medication and how frequently used: \_\_\_\_\_

**SLEEP HISTORY - DAYTIME SLEEPINESS**

31. During the LAST TWO WEEKS, has your adolescent struggled to stay awake (fought sleep) or fallen asleep in the following situations? (Mark one answer for every item)

	<b>No</b>	<b>Struggled to stay awake (fought sleep)</b>	<b>Fallen asleep</b>	<b>Don't Know</b>	<b>Does not Apply</b>
a. in a face-to-face conversation with another person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. traveling in a car, bus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. at the movies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. listening to the radio or stereo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. reading, studying or doing homework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. in a class at school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. while doing work on a computer or typewriter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. playing video games?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. eating a meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL HISTORY:**

32. Were there any problems with this pregnancy or delivery (prematurity, high blood pressure, etc.)? \_\_\_\_\_

33. What was the birth weight? \_\_\_\_\_

34. Was your adolescent ever on an apnea monitor at home? Yes  No

If yes, for how long? \_\_\_\_\_

35. Does your adolescent have any significant health problems? Yes  No

If so, please describe: \_\_\_\_\_

36. Has your adolescent ever been hospitalized? Yes  No

If yes, when: \_\_\_\_\_ What for? \_\_\_\_\_

37. Has your adolescent ever had any operations (other than tonsils/adenoids removal)?

Yes  No

If yes, type of operation? \_\_\_\_\_ Year \_\_\_\_\_

\_\_\_\_\_ Year \_\_\_\_\_

\_\_\_\_\_ Year \_\_\_\_\_

38. Have your adolescent's tonsils or adenoids been removed?

a. Tonsils: Yes  At what age? \_\_\_\_\_

For what reason: \_\_\_\_\_

b. Adenoids: Yes  At what age? \_\_\_\_\_

For what reason: \_\_\_\_\_

c. Describe briefly any changes you noticed in your adolescent's sleep or waking behavior after removal of tonsils or adenoids: \_\_\_\_\_

39. If NO, do you think the tonsils or adenoids are a problem? Yes  No  Don't know

For how long have they been a problem? \_\_\_\_\_ years

40. Has your adolescent ever broken his/her nose or other facial bones? Yes  No

41. Does your adolescent have difficulty breathing through his/her nose? Yes  No

42. In the past year, has your adolescent had strep throats/tonsillitis? \_\_\_\_\_

Yes  No

Frequent colds/respiratory infections?

Yes  No

Frequent sinus infections?

Yes  No

43. Does your adolescent have allergies?

Yes  No  Possibly

If yes, to what? \_\_\_\_\_

44. Does your adolescent have asthma? Yes  No  If "Yes", please answer the following questions:

In the **past year**....

a. How many days has your adolescent missed school due to asthma? \_\_\_\_\_ None

b. How many days has your adolescent been hospitalized for asthma? \_\_\_\_\_ None

c. List any medications your adolescent takes for asthma:

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

45. Does your adolescent frequently complain of heartburn? Yes  No  Don't know

Has he/she ever been diagnosed with gastroesophageal (stomach) reflux?

Yes  No  Only when younger

46. Has your adolescent had any head injuries requiring medical evaluation and/or treatment or loss of consciousness? If yes, please describe: \_\_\_\_\_

47. List any prescription or over-the counter medications your adolescent has taken in the last month:

Type: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

Type: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

Type: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

48. Menstrual history (Girls only):

a. Age she started menstruating \_\_\_\_\_ years

b. Regularity of her menstrual periods:

- About one per month (28 days)
- Usually much longer than one month between periods
- Usually shorter than one month between periods
- Very irregular; no apparent pattern
- Do not know

c. Number of days since her last menstrual period \_\_\_\_\_

49. Do you have additional comments about your adolescent's medical history? (Continue on additional sheets if necessary.)

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**HEALTH HABITS** - Please answer the following questions regarding health habits which may impact on sleep.

50. In the past month, how much did your adolescent use tobacco products?

- More than one pack (20 cigarettes) per day
- Between 5 and 20 cigarettes per day
- Between 1 and 5 cigarettes per day
- Less than 1 cigarette per day
- None
- Don't know

51. How much coffee did your adolescent drink?

- More than 3 cups glasses per day
- Between 1 and 3 cups per day
- Less than one cup per day
- None
- Don't know

52. How much caffeinated soda did your adolescent drink?

- More than 3 glasses per day
- Between 1 and 3 per day
- Less than one per day
- None
- Don't know

53. How much time does your adolescent spend on the computer on school days?

- 0-2 hours per day
- between 2 and 4 hours
- between 4 and 6 hours
- between 6 and 8 hours
- more than 8 hours
- don't know

54. How much time does your adolescent spend on the computer on weekend days?

- 0-2 hours per day       between 2 and 4 hours       between 4 and 6 hours  
 between 6 and 8 hours       more than 8 hours       don't know

**DEVELOPMENT HISTORY- PART A**

55. In what grade is your adolescent currently enrolled? \_\_\_\_\_ grade

56. What school does your adolescent attend this year? \_\_\_\_\_

57. Has your adolescent been diagnosed with:

	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
a. dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. a speech impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. a behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. other learning disorder (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

58. Is your adolescent enrolled in any special education (special needs) classes in school?

Yes     No    Please describe: \_\_\_\_\_

59. Does your adolescent have an Individualized Education Plan (I.E.P.) provided by the school?

Yes     No    If yes, for what reason: \_\_\_\_\_

60. Generally, how often does your adolescent attend school?

- a.  Every day
- b.  3-4 days per week
- c.  1-2 days per week
- d.  Less than once per week

61. Generally, how often is your adolescent late to school?

- a.  Every day
- b.  3-4 days per week
- c.  1-2 days per week
- d.  Less than once per week

**DEVELOPMENTAL HISTORY- PART B**

62. Does your adolescent have any significant behavioral or mental health problems

Yes  No

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

63. Has your adolescent ever received counseling for behavioral or mental health problems?

Yes  No  If so, for what reason? \_\_\_\_\_

Please give approximate dates:  
\_\_\_\_\_

64. Have you or your spouse ever been seen by a mental health counselor for concerns regarding your adolescent? Yes  No

If yes, for what reason? \_\_\_\_\_

65. To what organized groups does your adolescent currently belong? (e.g., team sports, scouts, church, groups, etc.) \_\_\_\_\_  
\_\_\_\_\_

**SLEEP BELIEFS**

In order to better understand your sense of the average teenager's sleep, please answer the following questions based on your beliefs for an average teenager (your adolescent's age) who does not have sleep problems?

- a. How many hours of sleep per night does the average teenager get? \_\_\_\_\_ hours
- b. How long does it take the average teenager to get to sleep? \_\_\_\_\_ minutes
- c. How many times does the average teenager wake up during the night? \_\_\_\_\_ times
- d. How long does the average teenager spend awake in bed during the night?  
\_\_\_\_\_ minutes or \_\_\_\_\_ hours
- e. Do you think most teenagers get enough sleep? Yes  No  Don't Know

**THANK YOU VERY MUCH FOR YOUR TIME!**