

**PEDIATRIC SLEEP CLINIC
 ADOLESCENT SLEEP HABITS SURVEY
 (GIRL'S SELF REPORT)**

Instructions: This form should be filled out by the adolescent patient herself if at all possible.

Today's Date: ____/____/____

1. Name: _____ 2. Date of Birth: ____/____/____

3. Please describe your sleep problem(s): _____

4. How long have you had difficulty with sleep? (check one)

- less than a month 1-6 months
 6-12 months 1-5 years
 more than 5 years

5. Have your problems with sleep gotten worse? Yes No Not sure

If yes, when did you notice that your sleep problems got worse: _____

6. What do you think is causing your sleep problem? (check all that apply)

- stress at school relationship problems with parents/family
 relationship problems with peers poor sleep habits
 poor eating habits a physical problem
 Other (describe briefly) _____

SLEEP HABITS: This set of questions asks about your usual sleep habits. Please answer as honestly as possible.

7. With whom do you share a bedroom? (check all that apply)

	Yes	No
Mother/step-mother	<input type="checkbox"/>	<input type="checkbox"/>
Father/step-father	<input type="checkbox"/>	<input type="checkbox"/>
Older brother(s)/sister(s)	<input type="checkbox"/>	<input type="checkbox"/>
Younger brother(s)/sister(s)	<input type="checkbox"/>	<input type="checkbox"/>
Other family member(s).....	<input type="checkbox"/>	<input type="checkbox"/>

8. In the last two weeks, have you slept in the same bed?

- every night almost every night
 a few nights not at all

The next set of questions has to do with your usual schedule on days when you have school. Please list both the USUAL times or number of hours/minutes, and the RANGE (earliest to latest, lowest to highest). Please check AM or PM for each time.

9. What time do you **usually** go to bed on school days? _____

Range: _____ AM/ PM to _____ AM/ PM

SLEEP HABITS (continued)

10. There are many reasons for doing things at one time or another. What is the **main reason** you usually go to bed at this time on school days? (check one)

- | | |
|---|---|
| <input type="checkbox"/> My parents have set my bedtime | <input type="checkbox"/> I feel sleepy |
| <input type="checkbox"/> I finish my homework | <input type="checkbox"/> My TV shows are over |
| <input type="checkbox"/> My brother(s) or sister(s) go to bed | <input type="checkbox"/> I finish socializing |
| <input type="checkbox"/> I get home from my job | <input type="checkbox"/> Other: _____ |

11. What time do you **usually** wake up on school days? _____

Range: _____ AM/ PM to _____ AM/ PM

12. There are many reasons for doing things at one time or another. What is the **main reason** you usually wake up at this time on school days? (check one)

- | | |
|---|---|
| <input type="checkbox"/> Noises or my pet wakes me up | <input type="checkbox"/> My alarm clock wakes me up |
| <input type="checkbox"/> My parents wake me up | <input type="checkbox"/> I need to go to the bathroom |
| <input type="checkbox"/> I don't know, I just wake up | <input type="checkbox"/> Other: _____ |

13. What time do you **usually** leave home on school days? _____

Range: _____ AM/ PM to _____ AM/ PM

14. How do you usually get to school? (check one)

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Walk | <input type="checkbox"/> Take the bus | <input type="checkbox"/> Get a ride with parent |
| <input type="checkbox"/> Get a ride with friend(s) | <input type="checkbox"/> Drive my car | |

What time do you need to arrive at school? _____

15. Figure out how long you **usually** sleep on a normal school night and fill it in here. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)

Usual amount of sleep: _____ hours and _____ minutes

Range: _____ hours and _____ minutes to _____ hours and _____ minutes

16. On school days, after you go to bed at night, about how long does it usually take you to fall asleep? (If longer than one hour, change to minutes.)

Usual amount: _____ minutes

Range: _____ minutes to _____ minutes

The next set of questions has to do with your usual schedule on days when you DO NOT have school, such as the weekend.

17. What time do you **usually** go to bed on weekends? _____

Range: _____ AM/ PM to _____ AM/ PM

18. There are many reasons for doing things at one time or another. What is the **main reason** you usually go to bed at this time on **weekends**? (check one)

- | | |
|---|---|
| <input type="checkbox"/> My parents have set my bedtime | <input type="checkbox"/> I feel sleepy |
| <input type="checkbox"/> I finish my homework | <input type="checkbox"/> My TV shows are over |
| <input type="checkbox"/> My brother(s) or sister(s) go to bed | <input type="checkbox"/> I finish socializing |
| <input type="checkbox"/> I get home from my job | <input type="checkbox"/> Other: _____ |

SLEEP HABITS (continued)

19. What time do you **usually** wake up on weekends? _____ AM/PM

Range: _____ AM/PM to _____ AM/PM

20. What is the **main reason** you usually wake up at this time on weekends? (check one)

- Noises or my pet wakes me up
- My alarm clock wakes me up
- My parents wake me up
- I need to go to the bathroom
- I don't know, I just wake up
- Other: _____

21. Figure out how long you **usually** sleep on a night when you do not have school the next day (such as a weekend night) and fill it in here. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)

Usual amount of sleep: _____ hours and _____ minutes

Range: _____ hours and _____ minutes to _____ hours and _____ minutes

22. On weekends, after you go to bed at night, about how long does it usually take you to fall asleep? (If longer than one hour, change to minutes.)

Range: _____ minutes to _____ minutes

23. Can you figure out how much sleep you need? Fill out how much sleep you think you would need each night to feel your best every day. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)

_____ hours _____ minutes

The following questions ask about other sleep habits you may have. Please answer as honestly as possible.

24. In the last two weeks, how often have you done any of the following activities in bed?

	Every day/night	Several times	Twice	Once	Never
Read?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watch TV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do schoolwork?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. When you have difficulty falling asleep or getting back to sleep, what do you do? (check all that apply)

- Stay in bed and try to get to sleep
- Do something in bed (e.g., read or watch TV)
- Get up and watch TV
- Get up and drink alcohol
- Get up and drink warm milk
- Get up and drink something? (circle all that apply: soda/water/coffee/tea)
- Get up and have a cigarette
- Other (please specify): _____

SLEEP HISTORY (GENERAL)

29. In an average 2 week period, how often do you...

(Check **ONE** answer for each question)

	Every day/night	5-6 times	3-4 times	1-2 times	Never	Don't know
need more than one reminder to get up in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
arrive late to class because you overslept?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fall asleep in a morning class?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fall asleep in a afternoon class?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feel tired, dragged out, or sleepy during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
go to bed because you just could not stay awake any longer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleep in past noon?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stay up until at least 3 am?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stay up all night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have an extremely hard time falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
awaken too early in the morning and couldn't get back to sleep?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have fearful thoughts or images as you are falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have nightmares or bad dreams during the night? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walk in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have a good night's sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wet your bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wake up once during the night?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wake up more than once during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
snore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
snore loudly?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stop breathing while you sleep or wake up gasping for breath?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feel satisfied with your sleep?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. Have you ever been unable to move when falling asleep or immediately upon waking?

Yes No Don't know

31. Have you ever had episodes of sudden muscular weakness (paralysis, inability to move) when laughing, angry, or in other emotional situations? Yes No Don't know

DAYTIME SLEEPINESS

32. People sometimes feel sleepy during the daytime. During your daytime activities, how much of a problem do you have with sleepiness (feeling sleepy, struggling to stay awake)?

- no problem at all a little problem more than a little problem
 a big problem a very big problem

33. Some people take naps in the daytime every day, others never do. When do you nap? (check all that apply)

- I never nap I nap every day I sometimes nap on school days
 I sometimes nap on weekends I never nap unless I am sick

34. During the last two weeks, have you struggled to stay awake (fought sleep) and/or fallen asleep in the following situations? (Check one answer for every item)

	No	Struggled to stay awake (fought sleep)	Fallen asleep	Does not apply
In a face-to-face conversation with another person?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traveling in a bus, train, plane or car?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending a performance (movie, concert, play)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching television?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading, studying, or doing homework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During a test?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a class at school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
While doing work on a computer or typewriter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing video games?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Riding a bicycle?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating a meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. **Complete only if you have a driver's license:**

Have you ever had a car accident(s) caused by your sleepiness (not due to alcohol or drugs)?

- Yes No Don't know

Have you ever had a near car accident(s) ("close calls") caused by your sleepiness (not due to alcohol or drugs)?

- Yes No Don't know

In the past month, how often have you driven while sleepy?

- never 1-2 times 3-4 times 5 or more times

SLEEP/WAKE RHYTHMS: For items 36-45, please check the response for each item that best describes you.

36. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
- 5:00-6:30 AM 6:30-7:45 AM 7:45-9:45 AM
 9:45-11 AM 11:00 AM-12:00 PM (noon)
37. Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
- 8:00-9:00 PM 9:00-10:15 PM 10:15 PM-12:30 AM
 12:30-1:45 AM 1:45-3:00 AM
38. Assuming normal circumstances, how easy do you find getting up in the morning? (check one)
- Not at all easy Slightly easy
 Fairly easy Very easy
39. How alert do you feel during the first half hour after having awakened in the morning? (check one)
- Not at all alert Slightly alert
 Fairly alert Very alert
40. During the first half hour after having awakened in the morning, how tired do you feel? (check one)
- Not at all tired Fairly tired
 Fairly refreshed Very refreshed
41. At what time in the evening do you feel tired and as a result in need of sleep?
- 8:00-9:00 PM 9:00-10:15 PM 10:15 PM-12:30 AM
 12:30-1:45 AM 1:45-3:00 AM
42. The bad news: you have to take a two-hour test. The good news: you can take it when you think you'll do your best. What time is that? Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
- 8:00-10:00 AM 11:00 AM-1:00 PM
 3:00-5:00 PM 7:00-9:00 PM
43. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be? (check one)
- Definitely a morning type More a morning type than evening type
 More an evening type than morning type Definitely an evening type
44. If you always had to rise at 6:00 AM, what do you think it would be like? (check one)
- Very difficult and unpleasant Rather difficult and unpleasant
 A little unpleasant but no great problem Easy and not unpleasant
45. How long does it usually take before you "recover your senses" in the morning after rising from a night's sleep? (check one)
- 0-10 minutes 11-20 minutes
 21-40 minutes More than 40 minutes

SCHOOL INFORMATION: The next set of questions are about school and other activities.

46. What grade are you in?

- 4 5 6 7 8 9 10 11 12

47. Are your grades in school mostly?

- A's A's & B's B's
B's & C's C's C's & D's
D's D's and F's

48. What is the highest grade in school you expect to complete? (check one)

- may not finish high school will finish high school
will get a college degree will get a degree beyond college

49. During the last 2 weeks, did you work at a job for pay? Yes No (If no skip to item 50)

What kind of job? _____

On average, how many hours did you work at your paying job per week:

during school week: _____ hours during the weekend: _____ hours

50. During the last 2 weeks, did you engage in organized sports or a regularly scheduled physical activity?

- Yes No (If no skip to item 51)

What kind of sport or activity? _____

On average, how many hours did you practice per week:

during school week: _____ hours during the weekend: _____ hours

51. During the last 2 weeks, did you participate in organized extracurricular activities? (For example, committees, clubs, volunteer work, musical groups, church groups, etc.) Yes No (If no skip to item 52)

What kind of sport or activity? _____

On average, how many hours did you work at your paying job per week:

during school week: _____ hours during the weekend: _____ hours

52. During the last 2 weeks, did you study/do homework? Yes No

On average, how many hours per week:

during school week: _____ hours during the weekend: _____ hours

53. Generally, how often do you attend school?

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

54. Generally, how often are you late to school?

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

HEALTH INFORMATION

(Questions 54-58 are about changes that may be happening to your body. These changes normally happen to different young people at different ages. If you do not understand a question or do not know the answer, just check "I don't know".)

54. Would you say that your growth in height? (check one)

- has not begun to spurt ("spurt" means faster growth than usual) has barely started
 is definitely underway seems complete
 I don't know

55. And how about the growth of your body hair? ("Body hair" means hair any place other than your head, such as under your arms). Would you say that your body hair grown: (check one)

- has not yet started to grow has barely started to grow
 is definitely underway seems completed
 I don't know

56. Have you noticed any skin changes, especially pimples: (check one)

- skin has not yet started changing skin has barely started changing
 skin changes are definitely underway skin changes seem complete
 I don't know

57. Have you noticed that your breasts have begun to grow: (check one)

- have not yet started growing have barely started changing
 breast growth is definitely underway breast growth seems completed
 I don't know

58. Have you begun to menstruate (started your period)? Yes No

If yes how old were you (years):

- 8 9 10 11 12 13 14 15 16 Older than 16 I don't know

59. Compared to other people your age, would you say that your health is:

- poor fair good excellent

60. During the last 2 weeks, how many days did you stay home from school because you were:

sick?: 1 2 3 4 5 6 7 8 9 10 Does not apply

other?: 1 2 3 4 5 6 7 8 9 10 Does not apply

Why did you stay home from school? _____

HEALTH HABITS: Please answer the following questions about health habits that can have effects on sleep.

61. During the LAST MONTH

How much did you use tobacco products?

- More than 1 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

If you smoke, at what time do you usually have your last cigarette of the day _____ AM/ PM

How much coffee did you drink?

- More than 3 glasses per day Between 1 and 3 glasses per day
 Less than one glass per day None

How much caffeinated soda did you drink?

- More than 3 glasses per day Between 1 and 3 glasses per day
 Less than one glass per day None

SLEEP BELIEFS

62. 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** adolescent who does **not** have sleep problems?

How many hours of sleep per night does the average teenager get? _____ hours

How long does it take the average teenager to get to sleep? _____ minutes

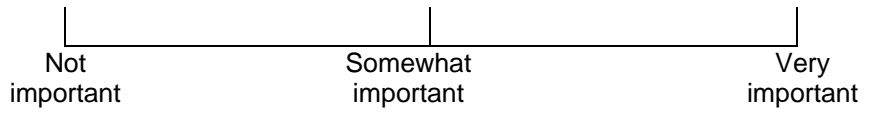
How many times does the average teenager wake up during the night? _____ times

How long does the average teenager spend awake in bed during the night? _____ minutes **OR** _____ hours

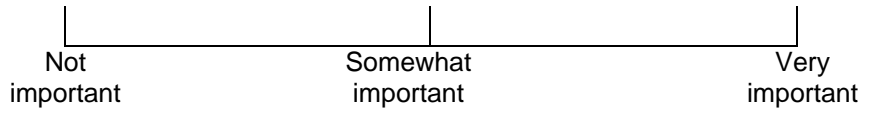
Do you think most teenagers get enough sleep? Yes No Don't Know

Please indicate how important the **average** teenager **thinks** the following health habits are:
(Please put an X on the line)

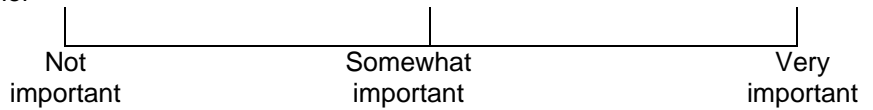
using sun screen



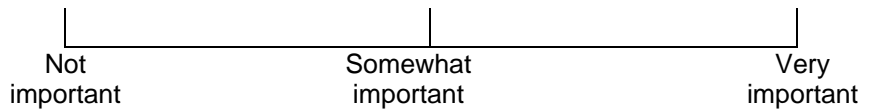
avoiding high fat foods



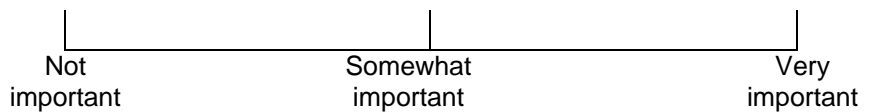
not driving after drinking alcohol



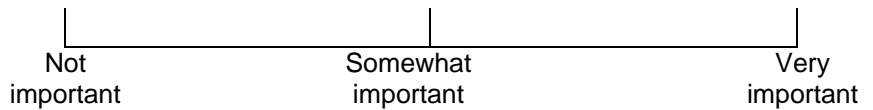
not driving while drowsy



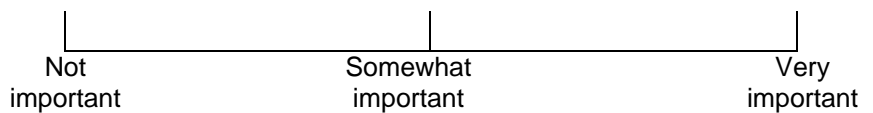
getting a good night's sleep



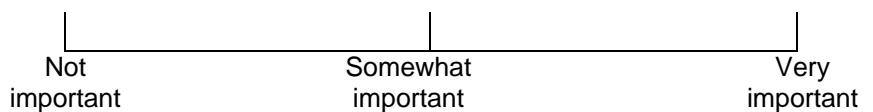
not smoking cigarettes



not using drugs



exercising regularly



SLEEP BELIEFS (continued)

Please indicate how likely the **average** teenager is to **do** the following are: (Please put an X on the line)

use sun screen

Not important | Somewhat important | Very important

avoid high fat foods

Not important | Somewhat important | Very important

not driving after drinking alcohol

Not important | Somewhat important | Very important

not driving while drowsy

Not important | Somewhat important | Very important

getting a good night's sleep

Not important | Somewhat important | Very important

not smoking cigarettes

Not important | Somewhat important | Very important

not using drugs

Not important | Somewhat important | Very important

exercising regularly

Not important | Somewhat important | Very important

THANK YOU VERY MUCH FOR YOUR TIME!