

Child's Name: _____ Child's Date of Birth: _____ Child's Age: _____
 Date form completed: _____ Who filled out form? **Mom** or **Dad** (please circle)

Child's Sleep Habits Questionnaire (CSHQ)

The following statements are about your child's sleep habits and possible difficulties with sleep. Think about the past week in your child's life when answering these questions. If last week was unusual for a specific reason (such as your child had an ear infection and did not sleep well or the TV set was broken), choose the most recent typical week. Answer **USUALLY** if something occurs **5 or more times** in a week; answer **SOMETIMES** if it occurs **2-4 times** in a week; answer **RARELY** if something occurs **never or 1 time** during a week.

Bedtime

Write in child's bedtime: week nights _____ weekends _____

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)
Child goes to sleep at the same time at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child falls asleep within 20 minutes after going to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child falls asleep in own bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child falls asleep in sibling's bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child falls asleep with rocking or rhythmic movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child needs special object to fall asleep (doll, special blanket, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child needs parent in room to fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is ready to go to bed at bedtime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child resists going to bed at bedtime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child struggles at bedtime (cries, refuses to stay in bed, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is afraid of sleeping in the dark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is afraid of sleeping alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep Behavior

Child's usual amount of sleep each day: week days _____ hours and _____ minutes
 (combining nighttime sleep and naps) weekends _____ hours and _____ minutes

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)
Child sleeps too little	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child sleeps too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child sleeps the right amount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child sleeps about the same amount each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep Behavior (Cont.)

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)
Child wets the bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child talks during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is restless and moves a lot during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child sleepwalks during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child moves to someone else's bed during the night (parent, brother, sister, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child reports body pains during sleep. If so, where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
Child grinds teeth during sleep (your dentist may have told you this)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child snores loudly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child seems to stop breathing during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child snorts and/or gasps during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has trouble sleeping away from home (visiting relatives, vacation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child complains about problems sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child awakens during night screaming, sweating, and inconsolable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child awakens alarmed by a frightening dream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Waking During the Night

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)
Child awakes once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child awakes more than once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child returns to sleep without help after waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Write in the number of minutes a night that waking usually lasts: _____

Morning Waking

Write in the time of day child usually wakes in the morning: weekdays _____ weekends _____

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)
Child wakes up by him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child wakes up with alarm clock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child wakes up in negative mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adults or siblings wake up child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has difficulty getting out of bed in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Morning Waking (Cont.)

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)
Child takes a long time to become alert in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child wakes up very early in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has a good appetite in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Daytime Sleepiness

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)
Child naps during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child suddenly falls asleep in the middle of active behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child seems tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past week your child has appeared sleepy or fallen asleep during the following (check all that apply):

	Very Sleepy	Falls Asleep
Dressing	<input type="checkbox"/>	<input type="checkbox"/>
Playing alone	<input type="checkbox"/>	<input type="checkbox"/>
Playing with others	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>
Riding in a car	<input type="checkbox"/>	<input type="checkbox"/>
Eating meals	<input type="checkbox"/>	<input type="checkbox"/>
Going to the bathroom	<input type="checkbox"/>	<input type="checkbox"/>