

TODAY'S DATE: ____/____/____

PARENT QUESTIONNAIRE
SCHOOL-AGED CHILDREN (4-12 years old)

PEDIATRIC SLEEP CLINIC QUESTIONNAIRE (4-12 YEAR OLDS)

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 child's sleep? _____

6. What do you think is causing your child's sleep problem? _____

7. When did your child's sleep problems start? _____

FAMILY INFORMATION

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

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

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

If divorced, child 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. Fathers's Marital Status: Married Divorced Separated Widowed Single

If divorced, child 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 child'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).

Family Member

Type of Sleep Problem

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).

Family Member

Type of Mental Health Problem

SLEEP HISTORY (GENERAL)

19. What time does your child usually go to bed on school nights? _____

Range: _____ am/pm to _____ am/pm

20. What is the main reason your child 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 child usually wake up on school day mornings? _____

Range: _____ am/pm to _____ am/pm

22. What usually wakes up your child 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 child 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 out 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 child usually go to bed on weekend nights? _____

Range: _____ am/pm to _____ am/pm

25. What time does your child usually wake up on weekend mornings? _____

Range: _____ am/pm to _____ am/pm

26. What usually wakes up your child 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 child 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 out 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 CHILD ...

(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"/>	_____
sleepwalk?	<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 child 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: _____

Does your child 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

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

	No	Struggled to stay awake (fought sleep)	Fallen asleep	Don't Know	Does not Apply
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?	<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:

31. Were there any problems with this pregnancy or delivery (prematurity, high blood pressure, etc.)? _____

32. What was the birth weight? _____

33. Was your child ever on an apnea monitor at home? Yes No

If yes, for how long? _____

34. Does your child have any significant health problems? Yes No

If so, please describe: _____

35. Has your child ever been hospitalized? Yes No

If yes, when: _____ What for? _____

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

Yes No

If yes, type of operation? _____ Year _____

_____ Year _____

_____ Year _____

37. Have your child'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 child's sleep or waking behavior after removal of tonsils or adenoids:

38. 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

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

40. Does your child have difficulty breathing through his/her nose? Yes No

41. In the past year, has your child had strep throats/tonsillitis? Yes No

Frequent colds/respiratory infections? Yes No

Frequent sinus infections? Yes No

42. Does your child have allergies? Yes No Possibly

If yes, to what? _____

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

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

a. How many days has your child missed school due to asthma? _____ None

b. How many days has your child been hospitalized for asthma? _____ None

c. List any medications your child takes for asthma:

Type: _____ Frequency: _____

Type: _____ Frequency: _____

Type: _____ Frequency: _____

44. Does your child frequently complain of heartburn? Yes No Don't know

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

Yes No Only when younger

45. Has your child had any head injuries requiring medical evaluation and/or treatment or loss of consciousness? If yes, please describe: _____

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

Type: _____ Reason for medication: _____

Type: _____ Reason for medication: _____

Type: _____ Reason for medication: _____

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

HEALTH HABITS - Please answer the following questions regarding health habits which may impact on sleep. In the past 2 weeks, on average:

48. How much caffeinated soda did your child drink?

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

49. How much television and/or videos did your child watch 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

a. How much time does your child 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

How much television and/or videos did your child watch 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

a. How much time does your child 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

50. Did your child watch TV and/or videos in the 30 minutes before falling asleep?

- every night
- 5-6 nights
- 3-4 nights
- 1-2 nights
- not at all

51. Does your child have a television set in his/her bedroom? Yes No

DEVELOPMENT HISTORY- PART A

52. In what grade is your child currently enrolled? _____ grade

53. What school does your child attend this year? _____

54. Has your child 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"/>	_____

55. Is your child enrolled in any special education (special needs) classes in school?

Yes No Please describe:

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

Yes No If yes, for what reason:

57. Generally, how often does your child attend school?

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

58. Generally, how often is your child 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

59. Does your child have any significant behavioral or mental health problems? Yes
No

If yes, please describe _____

60. Has your child ever received counseling for behavioral or mental health problems?
Yes No If so, for what reason?

Please give approximate dates:

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

If yes, for what reason? _____

62. To what organized groups does your child currently belong? (e.g., team sports, scouts, church, groups, etc.) _____

SLEEP BELIEFS

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

- a. How many hours of sleep per night does the average child need? _____ hours
- b. How many hours of sleep per night does the average child get? _____ hours
- c. How long does it take the average child to get to sleep? _____ minutes
- d. How many times does the average child wake up during the night? _____ times
- e. How long does the average child spend awake in bed during the night?
_____ minutes or _____ hours
- f. Do you think most children get enough sleep? Yes No Don’t Know

THANK YOU VERY MUCH FOR YOUR TIME!