Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

Sleep Center Questionnaire

Child's Name ______________________ Date of Birth ____________

Directions: Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

What are your major concerns about your child's sleep?

What things have you tried to help your child's problem?

SLEEP HISTORY

General Sleep

Does the child have a regular bedtime routine?	☐ Yes	☐ No
Does the child have his/her own bedroom?	☐ Yes	☐ No
Does the child have his/her own bed?	☐ Yes	☐ No
Is a parent present when your child falls asleep?	☐ Yes	☐ No

Child usually falls asleep in...
- ☐ own room in own bed (alone)
- ☐ parents' room in own bed
- ☐ parents' room in parents' bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed
- ☐ other: ____________

Child sleeps most of the night in...
- ☐ own room in own bed (alone)
- ☐ parents' room in own bed
- ☐ parents' room in parents' bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed
- ☐ other: ____________

Child usually wakes in the morning in...
- ☐ own room in own bed (alone)
- ☐ parents' room in own bed
- ☐ parents' room in parents' bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed
- ☐ Other: ____________

Child is usually put to bed by:
- ☐ Mother
- ☐ Father
- ☐ Both Parents
- ☐ Self
- ☐ Other ____________

Weekday Sleep Schedule

The child's usual bedtime on weekday nights _____ : _____ a.m. / p.m.

The child's usual waketime on weekday mornings _____ : _____ a.m. / p.m.

Weekend / Vacation Sleep Schedule

The child's usual bedtime on weekend/vacation nights _____ : _____ a.m. / p.m.

The child's usual waketime on weekend/vacation mornings _____ : _____ a.m. / p.m.

Nap Schedule

Number of days each week child takes a nap: 0 1 2 3 4 5 6 7

If child naps, write in usual nap time(s):

Nap 1: _____ : _____ a.m. / p.m. to _____ : _____ a.m. / p.m.

Nap 2: _____ : _____ a.m. / p.m. to _____ : _____ a.m. / p.m.

Child resists going to bed? ☐ Yes ☐ No

Child has difficulty falling asleep? ☐ Yes ☐ No

How long does it take to fall asleep? ________ minutes / hours

Child awakens during the night? ☐ Yes ☐ No

After nighttime awakening, child has difficulty falling back to sleep? ☐ Yes ☐ No

Child is difficult to awaken in the morning? ☐ Yes ☐ No

Child is a poor sleeper? ☐ Yes ☐ No

HEALTH HISTORY

Does your child drink caffeinated beverages? (Coke, Mountain Dew, iced tea) ☐ Yes ☐ No

Does your child exercise? ☐ Yes ☐ No

Is your child exposed to cigarette smoke? ☐ Yes ☐ No

Any recent changes in family situation or stressors? ☐ Yes ☐ No

If yes, please explain:

	never occurs	not often (less than once a week)	sometimes (1 to 2 times a week)	often (3 to 5 times a week)	always (6 to 7 times a week)	do not know
Current Sleep Symptoms						
Difficulty breathing when asleep						
Stops breathing during sleep						
Snores						
Restless sleep						
Sweating when sleeping						
Coughing at night						
Complain of upset stomach at night						
Poor appetite						
Nightmares						
Sleepwalking						
Sleeptalking						
Screaming in his/her sleep						
Kicks legs in sleep						
Wakes up at night						
Gets out of bed at night						
Trouble staying in his/her bed						
Resists going to bed at bedtime						
Grinds his/her teeth						
Wets bed						
Current Daytime Symptoms						
Trouble getting up in the morning						
Falls asleep in school						
Naps after school						
Uncomfortable or strange feeling in his/her legs						
Feels weak or loses control of his/her muscles with strong emotions						
Reports unable to move when falling asleep or upon waking						
Sees frightening visual images before falling asleep or upon waking						

MEDICAL AND PSYCHIATRIC HISTORY

Past Medical History

Frequent nasal congestion	☐ Yes	☐ No	
Trouble breathing through his/her nose	☐ Yes	☐ No	
Sinus problems	☐ Yes	☐ No	
Chronic bronchitis or cough	☐ Yes	☐ No	Age of diagnosis:
Allergies	☐ Yes	☐ No	Age of diagnosis:
Asthma	☐ Yes	☐ No	Age of diagnosis:
Frequent colds or ear/throat infections	☐ Yes	☐ No	
Difficulty swallowing	☐ Yes	☐ No	
Acid reflux (gastroesophageal reflux)	☐ Yes	☐ No	Age of diagnosis:
Poor or delayed growth	☐ Yes	☐ No	Age of diagnosis:
Excessive weight	☐ Yes	☐ No	Age of diagnosis:
Hearing problems	☐ Yes	☐ No	Age of diagnosis:
Speech problems	☐ Yes	☐ No	Age of diagnosis:
Vision problems	☐ Yes	☐ No	Age of diagnosis:
Seizures/Epilepsy	☐ Yes	☐ No	Age of diagnosis:
Morning headaches	☐ Yes	☐ No	
Cerebral palsy	☐ Yes	☐ No	Age of diagnosis:
Neuromuscular disease	☐ Yes	☐ No	Age of diagnosis:
Heart disease	☐ Yes	☐ No	Age of diagnosis:
High blood pressure	☐ Yes	☐ No	Age of diagnosis:
Sickle cell disease	☐ Yes	☐ No	Age of diagnosis:
Genetic disease	☐ Yes	☐ No	Age of diagnosis:
Chromosome problem (e.g., Downs')	☐ Yes	☐ No	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	☐ Yes	☐ No	Age of diagnosis:
Craniofacial disorder (e.g., Pierre-Robin)	☐ Yes	☐ No	Age of diagnosis:
Thyroid problems	☐ Yes	☐ No	Age of diagnosis:
Eczema (dry, itchy skin)	☐ Yes	☐ No	Age of diagnosis:

Past Psychological History

Autism	☐ Yes	☐ No	Age of diagnosis:
Developmental delay	☐ Yes	☐ No	Age of diagnosis:
Hyperactivity/ADHD	☐ Yes	☐ No	Age of diagnosis:
Anxiety/Panic Attacks	☐ Yes	☐ No	Age of diagnosis:
Obsessive Compulsive Disorder	☐ Yes	☐ No	Age of diagnosis:
Depression	☐ Yes	☐ No	Age of diagnosis:
Learning disability	☐ Yes	☐ No	Age of diagnosis:
Alcohol or substance use/abuse	☐ Yes	☐ No	Age of diagnosis:
Psychiatric Admission	☐ Yes	☐ No	Age of diagnosis:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist/school counselor.

Please list any medications your child currently takes:

	Medicine	Dose	How often?
1.			
2.			
3.			
4.			
5.			

Surgeries or Hospitalizations

Has your child ever had his/her tonsils removed?	☐ Yes ☐ No	Date of surgery:
Has your child ever had his/her adenoids removed?	☐ Yes ☐ No	Date of surgery:
Has your child ever had ear tubes?	☐ Yes ☐ No	Date of surgery:
Please list any additional hospitalizations or surgeries:		

Birth History

Any difficulty during pregnancy?	☐ Yes ☐ No
Any birth trauma during delivery?	☐ Yes ☐ No
Was your child delivered...	☐ Pre-term ☐ Full-term ☐ Post-term
Child's birthweight: ________________	
Only child?	☐ Yes ☐ No

FAMILY SLEEP HISTORY

Does anyone in the family have a sleep disorder? ☐ Yes ☐ No

If yes, mark the disorder(s) and check who in the family has the disorder:

Disorder				
☐ Insomnia	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Snoring	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Sleep apnea	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Sleep talking	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Narcolepsy	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Other: ____________	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent

SCHOOL PERFORMANCE (If school-aged)

Your child's year in school (grade): ____________

Has your child ever repeated a grade? ☐ No ☐ Yes

Is your child enrolled in any special education class? ☐ No ☐ Yes

How many school days has your child missed so far this year? ____________

How many school days did your child miss last year? ____________

How many school days was your child late so far this year? ____________

How many school days was your child late last year? ____________

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

____________________ ____________ ____________

Signature of Person Completing Form   Date   Time **(Required)**

____

Relationship to Patient

Reviewed with provider.

Provider Signature: ____________________ ____________ ____________

Date   Time **(Required)**