



515 SW Home, Suit 200, Topeka, KS 66606  
785-234-5480

**Pediatric Sleep Questionnaire**



Childs Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_ School Grade: \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_

Person answering Questionnaire: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip \_\_\_\_\_

Day Telephone: (\_\_\_\_) \_\_\_\_\_ Evening Telephone: (\_\_\_\_) \_\_\_\_\_

1. Please describe your child's sleep problem:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When did you first notice the problem? \_\_\_\_\_

3. Please list any medications your child is using:

Medication	Dose	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. When in bed, does your child: Watch T.V. Read Listen to Radio

5. When sleeping, does your child.....

Ever snore?	Yes	No
Snore more than half the time?	Yes	No
Snore loudly?	Yes	No
Have heavy or loud breathing?	Yes	No
Awaken with snoring snorting sound?	Yes	No
Have brief leg jerks or kicks, one or both legs with repeated jerking or kicking at regular intervals?	Yes	No
Have restless sleep? (toss & turn, move all around the bed, pull covers off the bed, etc.)	Yes	No
Get out of bed at night?	Yes	No

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

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

6. Has your child ever stopped breathing at night? Yes No  
If Yes, how often? \_\_\_\_\_

7. Have you ever had to shake or move your child to get them to breathe again?  
Yes No When was the last time this occurred? \_\_\_\_\_

9. Does your child sleep in a room alone? Yes No  
If not with whom? \_\_\_\_\_

10. Is there regular "lights out", bedtime each night? Yes No  
When? \_\_\_\_\_

11. Who turns lights out? Adult Child

12. On average, how long does it take your child to fall asleep? \_\_\_\_\_

13. Is there difficulty or bed behavior at bed time? Yes No

14. How often does your child wake up at night? 1-3 times 4-6 times more

15. Does your child wake up and go to the restroom at night? Yes No

16. Does your child wet the bed? Yes No

17. How often? Nightly Weekly Seldom

18. What time does your child get up in the morning? \_\_\_\_\_

19. Is the child difficult to awaken? Yes No Sometimes

20. Has your child ever had "sleep walking" episodes? Yes No

21. Have you ever been awakened by the sound of your child, screaming or crying at night?  
Yes No

22. Has your child ever come to you at night because of "bad dreams"? Yes No

23. When asleep, does your child rock his/her body? Yes No

24. When asleep does your child bang his/her head on the pillow? Yes No

25. Does your child regularly nap during the day? Yes No  
(If yes, when and how long) \_\_\_\_\_

26. How long do you think children the same age as your child should sleep each night? \_\_\_\_\_

27. Has a teacher ever told you that your child "day dreams" or has difficulty paying attention in school?  
Yes No  
When? \_\_\_\_\_

28. Has your child ever fallen asleep in school? Yes No  
(if yes) How often? \_\_\_\_\_

29. Has your child ever simply stopped his/her activity and taken a nap where he/she was?  
Yes      No      How often?      Daily      Weekly      Monthly

30. Has your child ever seemed to be dreaming (seeing images or hearing sounds) while still awake?  
Yes      No      How often?      Daily      Weekly      Monthly

31. On average, how many caffeinated beverages (cola, tea, coffee) does your child drink?  
Daily \_\_\_\_\_ Weekly \_\_\_\_\_

32. Does your child use tobacco products of any kind?      Yes      No  
What? \_\_\_\_\_

33. Has your child ever seemed to lose control of his/her arms (dropping objects) or leg (stumbling) involuntarily?      Yes      NO      How often? \_\_\_\_\_

34. Has your child ever become weak or unsteady when excited, surprised or emotional (laughing or crying)?      Yes      No  
(If yes) how often? \_\_\_\_\_

35. Does your child still have Tonsils?      Yes      NO      (if no), When were they removed? \_\_\_\_\_

36. Has a health professional ever said that your child has Attention -Deficit Disorder (ADD) or Attention-Deficit /Hyperactivity Disorder (ADHD)?      Yes      No  
When? \_\_\_\_\_

37. Any additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_