# Sleep Intake Questionnaire

**Patient’s Name:**

**Today’s Date:** __/__/____ **Time:** __:__

**Referring Physician:**

**Patient’s Date of Birth:** __/__/____

**Primary Care Physician:**

**Medical Record Number (MR #):**

What sleep problem is your child having that you or your doctor are concerned about?

<table>
<thead>
<tr>
<th>Person completing form:</th>
<th>Relationship to patient:</th>
</tr>
</thead>
</table>

## SLEEP ENVIRONMENT

1. **Does your child have a set bedtime?**
   - [ ] No
   - [ ] Yes

2. **What time does your child usually:**
   - Go to bed on a weekday? ______ AM / PM
   - Go to bed on the weekend? ______ AM / PM
   - Awaken in the morning on a weekday? ______ AM / PM
   - Awaken in the morning on the weekend? ______ AM / PM

3. **What is your child’s usual bedtime ritual? (What does your child do prior to going to bed?)**

4. **In which room does your child usually sleep at night?**
   - [ ] His/Her own bedroom
   - [ ] Bedroom shared with sibling
   - [ ] Parent’s (your) bedroom
   - [ ] Family / Living room
   - [ ] Other room, please describe: ______

5. **Where does he/she sleep? (Check all that may apply)**
   - [ ] Bed
   - [ ] Crib
   - [ ] Couch
   - [ ] Chair
   - [ ] Floor
   - [ ] Sleeps in same bed with sibling
   - [ ] Sleeps in same bed with parent
   - [ ] Other, please describe: ______

6. **Which of the following is in the room where your child sleeps?**
   - [ ] Television
   - [ ] No
   - [ ] Yes
   - [ ] Music
   - [ ] No
   - [ ] Yes
   - [ ] Computer
   - [ ] No
   - [ ] Yes
   - [ ] Telephone
   - [ ] No
   - [ ] Yes
   - [ ] Mobile phone
   - [ ] No
   - [ ] Yes
   - [ ] Pet(s)
   - [ ] No
   - [ ] Yes

7. **Does your child require special conditions in order to sleep at night? (Check all that may apply)**
   - [ ] No special conditions required
   - [ ] Cold temperature
   - [ ] Bedroom light on
   - [ ] Open window
   - [ ] Other: ______

8. **Does your child use any of the following during his/her sleep at night?**
   - [ ] No breathing support
   - [ ] Oxygen
   - [ ] CPAP
   - [ ] BiPAP
   - [ ] Other: ______

9. **How many pillows does your child usually sleep with?**
   - [ ] None
   - [ ] One
   - [ ] Two
   - [ ] Three
   - [ ] Four or more

10. **Does your child feel safe in his/her sleeping environment?**
    - [ ] No
    - [ ] Yes

11. **Does your child sleep:**
    - [ ] With his / her neck hyperextended (lifted up in the air)
      - [ ] Never
      - [ ] Some nights
      - [ ] Most nights
      - [ ] Every night
    - [ ] With his / her bottom up in the air
      - [ ] Never
      - [ ] Some nights
      - [ ] Most nights
      - [ ] Every night
    - [ ] In a position you feel is unusual
      - [ ] Never
      - [ ] Some nights
      - [ ] Most nights
      - [ ] Every night

If your child sleeps in a position you feel is unusual, please describe: ______
## SLEEPING PROBLEMS

12. During the past 3 months, has your child experienced any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Never</th>
<th>Some nights</th>
<th>Most nights</th>
<th>Every night</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty falling asleep</td>
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<tr>
<td>Trouble staying asleep</td>
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<tr>
<td>Restless sleeping (frequently moving about)</td>
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<td>Change in skin color, turns pale or blue</td>
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<tr>
<td><em>Breathing during sleep interrupted by long pauses (10 or more seconds of absent/shallow breathing)</em></td>
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<tr>
<td><em>Breathing during sleep interrupted by gasping or choking</em></td>
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<tr>
<td>Sweating during sleep</td>
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<tr>
<td>Jaw clenching</td>
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<td>Teeth grinding</td>
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<td>Mouth breathing</td>
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<tr>
<td>Gets out of bed to urinate</td>
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<tr>
<td><em>Wets the bed at night</em></td>
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<tr>
<td>Crawling sensation in legs</td>
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<tr>
<td>Nightmares</td>
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<tr>
<td>Night Terrors</td>
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<tr>
<td>Sleep talking</td>
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<tr>
<td>Sleep walking</td>
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</tbody>
</table>

13. Have you had any treatments at home for any of these conditions?

14. Do you ever have to wake your child up to help him/her breathe?  
   - No  
   - Yes

15. Does your child experience sleep problems at different times of the year?  
   - No  
   - Yes

If yes, please explain: ____________________________

## SNORING

16. Does your child snore at night?  
   - Never  
   - Some nights  
   - Most nights  
   - Every night

* If your child snores at night, please describe the loudness of the snoring:
   - My child does not snore  
   - Barely audible in room  
   - Easily heard in room, but not outside the bedroom  
   - Audible outside room  
   - Other: ____________________________
**AWAKENING**

17. In the morning, does your child experience any of the following?

<table>
<thead>
<tr>
<th>Awakens refreshed and rested</th>
<th>□ Never □ Some mornings □ Most mornings □ Every morning</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Awakens tired and still sleepy after a full night’s sleep</em></td>
<td>□ Never □ Some mornings □ Most mornings □ Every morning</td>
</tr>
<tr>
<td>Awakens coughing</td>
<td>□ Never □ Some mornings □ Most mornings □ Every morning</td>
</tr>
<tr>
<td>Awakens choking</td>
<td>□ Never □ Some mornings □ Most mornings □ Every morning</td>
</tr>
<tr>
<td><em>Awakens with a headache</em></td>
<td>□ Never □ Some mornings □ Most mornings □ Every morning</td>
</tr>
<tr>
<td>Needs help to awaken</td>
<td>□ Never □ Some mornings □ Most mornings □ Every morning</td>
</tr>
</tbody>
</table>

18. Does your child awaken with a problem other than those above?  □ No  □ Yes
If yes, please explain: ___________________________________________________________

**DAYTIME SLEEPINESS**

19. In the following situations, what is the chance your child would doze off or fall asleep?

<table>
<thead>
<tr>
<th>Situation</th>
<th>□ No</th>
<th>□ Slight</th>
<th>□ Moderate</th>
<th>□ High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
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<tr>
<td>Sitting, inactive in a public place (e.g. theatre or meeting)</td>
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<tr>
<td><em>As a passenger in a car for an hour without a break</em></td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after a lunch</td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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</tbody>
</table>

Citation: Modified Epworth Sleepiness Scale from Melendres, Lutz, Rubin, Marcus, Pediatrics 2004; 114:768-775 based on the original Epworth Sleepiness Scale from Johns, Sleep 1991; 14:540-545.

*20. How often does your child have trouble staying awake throughout the entire day?*  □ Never   □ Sometimes □ Often □ Always

21. How often does your child take a daytime nap?  □ Never □ Sometimes □ Often □ Always

22. If your child does take a nap, how long is the nap?  □ Does not nap □ ½ hour or less □ ½ hour – 1 hour □ 1 – 2 hours □ Greater than 2 hours

23. Has napping changed in the past two years?  □ No □ Yes

24. Does your child experience his / her body sagging or becoming limp when upset (angry) or surprised?  □ No □ Yes

25. Does your child experience his / her head & neck becoming limp when angry?  □ No □ Yes

26. Does your child experience his / her head & neck becoming limp when laughing?  □ No □ Yes

27. Does your child fall asleep during the day even when trying to stay awake?  □ No □ Yes

28. Does your child report having vivid (colorful) dreams or daydreams when falling asleep?  □ No □ Yes

29. Does your child report having vivid (colorful) dreams or daydreams when awakening from a nap or overnight sleep?  □ No □ Yes

30. Does your child report feeling paralyzed (unable to move) when falling asleep or when awakening from a nap or overnight sleep?  □ No □ Yes
### Overall Health

31. How is your child's performance in school?  □ Below grade level  □ At grade level  □ Above grade level  □ N/A

32. Has your child's performance changed in the past two years?  □ No  □ Yes
If yes, please explain: ____________________________________________________________

33. Where does your child have behavioral problems?  □ My child does not have behavioral problems
□ With peers/playmates  □ In school  □ At home  □ Other: ___________________________

34. Does your child have any stress or anxiety due to a recent change at home or at school?  □ No  □ Yes
If yes, please explain: ____________________________________________________________

35. Has there been any change in performance in sports in the past 3 months?  □ No  □ Yes

36. Has your child missed any school days due to sleep problems?  □ No  □ Yes
If yes, how many in the past 2 months? __________

37. How often has your child been late for school due to sleep problems?
□ Never  □ Less than monthly  □ Monthly  □ At least weekly

38. Does your child have: (Check all that may apply)
□ Developmental delay  □ Hyperactivity  □ Sad mood  □ Frequent colds  □ Learning disabilities
□ Irritable mood  □ Overweight  □ Seasonal issues  □ Difficulty concentrating  □ Fatigue / Tiredness
□ Hay fever/allergies  □ ADHD  □ Depression  □ Asthma  □ None of the above
□ Other: ___________________________________________________________________

39. On a typical day, does your child drink any energy drinks or caffeinated beverages (cola, tea, coffee, Jolt®, Mountain Dew®, Red Bull®, Monster®, ROCKSTAR Energy Drink ©)?  □ No  □ Yes
If yes, how many cups or cans in a typical day? __________

40. Does anyone in the household smoke?  □ No  □ Yes
If yes, please explain: ____________________________________________________________

41. Does anyone in the household use cigarettes, smokeless tobacco, snuff, or other tobacco products?  □ No  □ Yes  □ N/A
If yes, which ones and how often? __________________________________________________________________

42. Does your child use any recreational drugs that you know of?  □ No  □ Yes  □ N/A
If yes, which ones and how often? __________________________________________________________________
**MEDICATIONS**

43. Does your child take any of the following?

- Prescription medications  □ No  □ Yes
- Over-the-counter medications  □ No  □ Yes
- Herbal Remedies or Nutritional Supplements  □ No  □ Yes

*If Yes, please list below:*

<table>
<thead>
<tr>
<th>Prescription Medication Name</th>
<th>How much?</th>
<th>How often?</th>
<th>Last taken?</th>
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</thead>
<tbody>
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<td>5.</td>
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<table>
<thead>
<tr>
<th>Over-the-counter Medication Name</th>
<th>How much?</th>
<th>How often?</th>
<th>Last taken?</th>
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<thead>
<tr>
<th>Herbal Remedy / Nutritional Supplement Name:</th>
<th>Last taken?</th>
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<tbody>
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<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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</table>

Thank you for sharing with us information about your family and child. This information will help our specialists diagnose health concerns, interpret your child’s sleep study and develop treatment plans.

**Information Reviewed By:** Initials: ____________

**Guardian’s Signature:** ________________________  **Date:** ____________  **Time:** ____________

**Abbreviations**

- CPAP – Continuous Positive Airway Pressure
- BiPAP – Bi-level Positive Airway Pressure
- MR # – Medical Record Number

- ADHD – Attention Deficit Hyperactivity Disorder
- N/A – Not applicable