Pediatric Sleep Disorders Center Intake Questionnaire

What is your/your child's primary sleep concern?	(for office use) PT LABEL

Instructions for #1-43: Circle Yes (Y), No (N), or Don't Know (DK).	Yes	No	Don't Know	If YES, complete. If NO, leave this blank.
Please answer questions 1 – 28 about your child's sleep during the PAST 4 WEEKS.				
1. While sleeping, does your child snore?	Y	N	DK	# days per week: _____
2. While sleeping, does your child have "heavy" or loud breathing?	Y	N	DK	# days per week: _____
3. While sleeping, does your child have trouble breathing, or struggle to breathe?	Y	N	DK	# days per week: _____
4. Does your child snort and/or gasp during sleep?	Y	N	DK	# days per week: _____
5. Have you seen your child stop breathing during the night?	Y	N	DK	# days per week: _____
6. Does your child tend to breathe through the mouth during the day?	Y	N	DK	# days per week: _____
7. Does your child have a dry mouth or sore throat on waking up in the morning?	Y	N	DK	# days per week: _____
8. Does your child go to bed at the same time at night?	Y	N	DK	# days per week: _____
9. Does your child fall asleep alone in his/her own bed?	Y	N	DK	# days per week: _____
10. Does your child fall asleep within 20 minutes after going to bed?	Y	N	DK	# days per week: _____
11. Does your child sleep the right amount?	Y	N	DK	# days per week: _____
12. Does your child sleep the same amount each day?	Y	N	DK	# days per week: _____
13. Does your child fall asleep in parent's or sibling's bed?	Y	N	DK	# days per week: _____
14. Does your child struggle at bedtime (cries, refuses to stay in bed, etc.)?	Y	N	DK	# days per week: _____
15. Does your child need a parent in the room to fall asleep?	Y	N	DK	# days per week: _____
16. Is your child afraid of sleeping alone?	Y	N	DK	# days per week: _____
17. Is your child afraid of sleeping in the dark?	Y	N	DK	# days per week: _____
18. Does your child have trouble sleeping away from home (visiting relatives, vacation)?	Y	N	DK	# days per week: _____
19. Does your child move to someone else's bed during the night (parent, sibling, etc.)?	Y	N	DK	# days per week: _____
20. Does your child awaken once during the night?	Y	N	DK	# days per week: _____
21. Does your child awaken more than once during the night?	Y	N	DK	# days per week: _____
22. Does your child talk during sleep?	Y	N	DK	# days per week: _____
23. Is your child restless and move a lot during sleep?	Y	N	DK	# days per week: _____
24. Does your child sleepwalk during the night?	Y	N	DK	# days per week: _____
25. Does your child wet the bed at night?	Y	N	DK	# days per week: _____
26. Does your child grind his/her teeth during sleep? (your dentist may have told you this)	Y	N	DK	# days per week: _____
27. Does your child awaken alarmed by a frightening dream?	Y	N	DK	# days per week: _____
28. Does your child awaken during the night screaming, sweating, and inconsolable?	Y	N	DK	# days per week: _____
Please answer questions 29-43 about your child's daytime behavior in the PAST 4 WEEKS.				
29. Does your child wake up by him/herself in the morning?	Y	N	DK	# days per week: _____
30. Does your child wake up in a negative mood?	Y	N	DK	# days per week: _____
31. Does your child take a long time to become alert in the morning?	Y	N	DK	# days per week: _____
32. Does your child seem tired/unrefreshed in the morning?	Y	N	DK	# days per week: _____
33. Does your child wake up with headaches in the morning?	Y	N	DK	# days per week: _____
34. Does your child have problems with sleepiness during the day?	Y	N	DK	# days per week: _____
35. Has a teacher/supervisor commented that your child appears sleepy during the day?	Y	N	DK	# days per week: _____
36. Does your child seem NOT to listen when spoken to directly?	Y	N	DK	# days per week: _____
37. Does your child have difficulty organizing tasks and activities?	Y	N	DK	# days per week: _____

Continued ➡

38. Is your child easily distracted by extraneous stimuli?	Y	N	DK	# days per week: _____
39. Does your child fidget with hands or feet, or squirm in seat?	Y	N	DK	# days per week: _____
40. Does your child seem "on the go" or often act as if "driven by a motor"?	Y	N	DK	# days per week: _____
41. Does your child interrupt or intrude on others (e.g., butt into conversations or games)?	Y	N	DK	# days per week: _____
42. Does your child have "sleep attacks" or cataplexy (episodes of sudden weakness)?	Y	N	DK	# days per week: _____
43. Does your child feel paralyzed when trying to wake up or fall asleep?	Y	N	DK	# days per week: _____

Questions 46-47 are about your child's overall health. Please circle Yes, No, or Don't Know.

44. Has your child grown at a <u>less than normal</u> rate at any time since birth?	Y	N	DK	
45. Does your child take any chronic medications (for longer than 4 weeks)?	Y	N	DK	

If yes → Please list the medications

	Medicine	Reason for Taking Medicine	Dose	# Doses per Day
If you need more space, please use a separate piece of paper	1.			
	2.			
	3.			
	4.			

For questions 46-49, "usually" means more than half the time.

46. How much total sleep in a 24 hour periodic does your child get?	a. On weekdays?	_____ hours
	b. On weekends or vacation?	_____ hours
47. How long does it usually take your child to fall asleep each night?		_____ minutes
48. What time does your child usually go to bed and wake up?	a. On weekdays?	___:___ to ___ : ___
	b. On weekends or vacation?……..	___:___ to ___ : ___
49. How many hours does your child usually nap during the day:	a. On weekdays?	_____ hours
	b. On weekends or vacation? ……..	_____ hours

Question 50 is specifically about when your child was an infant.

50. Right after your child was born, did they require any of the following: (check all that apply):

☐ Apnea Monitor ☐ Caffeine ☐ Oxygen ☐ Pulse oximeter ☐ None of these ☐ Other: (please describe)_____

For questions 51-54, please indicate whether your child has had any of the procedures or diagnoses listed.

51. Has your child ever had surgery to remove tonsils and/or adenoids?	Yes	No
52. Has your child ever been treated at home with Continuous, Bi-level, or Variable Positive Airway Pressure (CPAP, Bi-PAP or VPAP)? *This machine helps keep the airway open using a mask that is placed over the nose and or mouth.*	Yes	No
53. Has your child ever had polysomnography (an overnight sleep study) at another facility? If yes, at what facility? ……	Yes	No
54. Has a provider ever diagnosed your child with sleep apnea or sleep disordered breathing?.....	Yes	No

Questions 55-56 pertain to household and immediate family members.

55. Does anyone who lives at home work variable shifts such as night shift?	Yes	No
56. Has a provider ever diagnosed an <u>immediate family member</u> with sleep disordered breathing or sleep apnea	Yes	No

If yes → a. Which family member(s)? (check all that apply)

☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Grandmother ☐ Grandfather ☐ Other

Questions 56-58 are specifically about school (preschool/daycare) and attendance.

56. Current grade in school: _____ 57. How many absences this year (estimated): _____ 58.How many morning tardies this year:_____