PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

Tel. 907-331-3640
Fax. 907-331-3647
www.peakneurology.com

Pediatric Sleep Questionnaire

Name _____ **SSN** ____-____-_____ **Date** _____

Age _____ **Date of Birth** _____ **Male / Female (circle)** **Height** _____ **Weight** _____

Language: _____ **Race:** _____ **Ethnicity:**_____

Parent / Guardian: _____

Primary Insurance: _____

Pediatrician / Referring Provider: _____

Home Address:

_____ **Home Phone:** _____

_____ **Work Phone:** _____

_____ **Cell Phone:** _____

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

_____

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

_____

Sleep History Does your child have a regular sleep time? **Yes** **No**

	Weekdays	Weekends
What time does your child go to bed?		
What time does your child get up in the morning?		
How many hours of sleep does your child get each night?		
How many hours does he/she nap per day?		

Current Sleep Symptoms

In the past month, have you observed your child:	**Yes**	**No**	**Don't Know / Not Sure**
Snoring more than ½ of observed nights?			
Always snoring?			
Snoring loudly?			
Have "heavy" or "loud" breathing?			
Have trouble breathing, or struggle to breath?			
Stop breathing during the night?			
Breathing through their mouth during the day?			
Have a dry mouth when waking up?			
Occasionally wet the bed?			
Wake up unrefreshed?			
Have a problem with sleepiness during the day?			
Has a teacher commented that your child looks sleep?			
Is it hard to wake your child in the morning?			
Does your child wake with headaches in the morning?			
Did your child stop growing at a normal rate since birth?			
Is your child overweight?			
Seeming to not listen when spoken to directly?			
Having difficulty organizing tasks and activities?			
Easily distracted by extraneous stimuli?			
Fidgeting with hands/feet or squirming in a seat?			
Is "on the go" or often "acts as if driven by a motor?			
Interrupts or intrudes on others (eg. When talking)?			

Current Daytime Symptoms

Does your child...	Never	Sometimes (1-2 nights per week)	Routinely (3-5 nights per week)	Always (6-7 nights per week)	I do not know
Have trouble getting up in the morning					
Fall asleep at school					
Nap after school or at inappropriate times					
Have daytime sleepiness					
Have hyperactivity or behavioral problems					

Movement

Does your child complain of an uncomfortable feeling in his/her legs (creepy-crawly feeling) during the waking hours? **Yes** **No**

Does your child kick his/her legs during sleep? **Yes** **No**

Parasomnias (Sleep problems at night)

Does your child currently have nightmares or night terrors? **Yes** **No**

Does your child grind or clench his/her teeth at night? **Yes** **No**

Does your child frequently wet the bed? **Yes** **No**

Does your child walk in his/her sleep? **Yes** **No**

Does your child talk in his/her sleep? **Yes** **No**

Has your child ever reported sudden muscle weakness or lose control of his/her muscles with strong emotions? **Yes** **No**

Does your child report inability to move when falling asleep or waking up? **Yes** **No**

Does your child report vivid dreams just before falling asleep or waking up? **Yes** **No**

Medical and Surgical History

Has your child ever had airway surgery, such as a tonsillectomy or adenoidectomy? **Yes** **No**

Has your child ever been hospitalized? **Yes** **No**

If so, for what? _____

Has your child had any other major surgeries? **Yes** **No**

If so, what? _____

What type of delivery did your child have? _____ / Were there any problems at birth? **Yes** **No**

Mark any of the following disorders that your child has been diagnosed with (active problem or cured)		
	Yes	No
Obstructive Sleep Apnea		
Frequent nasal congestion		
Trouble breathing through nose		
Sinus problems		
Chronic bronchitis		
Allergies		
Asthma		
Frequent ear infections		
Reflux disease		
Poor or delayed growth		
Obesity		
Hearing problems		
Speech problems		
Vision problems		
Seizures/Epilepsy		
Cerebral palsy		
Heart disease		
High blood pressure		
Genetic disease		
Head/brain injury		

Write any other medical problems your child has that are not listed:

_____

_____

_____

_____

Please list any medications that your child is currently taking, including prescriptions, over the counter medications, and herbal medications:

_____

_____

_____

_____

_____

_____

_____

Past Psychological History

Mark any of the following disorders that your child has been diagnosed with (active problem or cured)		
	Yes	No
Autism		
Developmental Delay		
Hyperactivity/ADHD		
Anxiety		
Obsessive Compulsive Disorder		
Depression		
Learning disability		
Drug use/abuse		
Behavioral Disorder		
Psychiatric admission		

Write any other problems your child has that are not listed above:

_____

_____

_____

Social History

Does your child drink alcohol? **Yes** **No**
If yes, how many drinks per day? _____
Does your child smoke cigarettes? **Yes** **No**
Is your child exposed to cigarette smoke? **Yes** **No**
Does your child drink caffeinated beverages? **Yes** **No**
If yes, how many drinks per day? _____
Does your child use illicit drugs? **Yes** **No**
If yes, please list _____
Does your child have his/her own bedroom? **Yes** **No**
Is there a TV (or other electronics) in the bedroom? **Yes** **No**
Does your child co-sleep? **Yes** **No**

Family History

Is there a history of crib death (SIDS) in your family? **Yes** **No**
Does anyone in the family have a sleep disorder? **Yes*** **No**

*If yes, mark the disorders and relationship	Mother	Father	Brother/sister	Grandparent
Insomnia				
Snoring				
Sleep Apnea (using CPAP)				
Restless Legs Syndrome				
Sleep walking				
Narcolepsy				
Other (please list): _____				

School Performance

Child's grade:		
	Yes	No
Has your child ever repeated a grade?		
Is your child enrolled in special education classes?		
How many school days has your child missed this year:		
What have your child's grades been this year?		
What were your child's grades last year?		

Please write any other comments about your child's sleep that was not already covered:

_____

_____

_____

_____

_____

_____

Your child's history is important and helps us to properly assess your child's sleeping problem.
Thank you for taking the time to thoroughly complete this questionnaire!