POMONA VALLEY HOSPITAL
MEDICAL CENTER
SLEEP DISORDERS CENTER

Pediatric Sleep Questionnaire
Infant – 5 years

Name:_____
First Middle Last

Sex: Male Female Date of Birth:_____

Mother's Name:_____ Father's Name:_____

Please circle or fill in the answer.

1. Describe what the sleep problem is:_____
2. How long has this been a problem:_____
3. How serious do you believe this problem is?
   VERY SERIOUS
   SOMEWHAT SERIOUS
   NOT AT ALL SERIOUS
4. Who puts the child to bed?_____
5. Where does the child fall asleep? Own bed, Parents' bed, being held, rocked, fed, room other than child's bedroom.
6. Does child need a bottle, Pacifier, or special object to fall asleep?
7. Who puts the child to bed?_____
8. Is the child put in bed Awake or Asleep?
9. Is there a bedtime ritual (routine)? Yes No
   How important is this routine for the child?_____
10. Please describe bedtime ritual:_____
    _____
    _____
    _____
11. How long does the bedtime ritual take? _____
12. Is the bedtime ritual Pleasant? YES NO _____

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13. Is bedtime at a regular time every night (including weekends)? Yes No _____

14. Does the child use sleep medication? Yes No if yes, what? _____

15. Who else sleeps in the child's room? _____

16. Describe an average evening from dinner to bedtime. _____

Check any of the following that have been observed in the child.

	Refuses to go to bed		Awakens at night for a drink or feeding
	Repeatedly gets out of bed		Awakens during night and gets into parent's bed
	Refuses to sleep alone		Bangs head or rocks until asleep
	Cries until asleep		Reluctant to go to sleep due to fears
	Has frightening dreams		Insists on sleep with parents, etc.
	Can relate details of frightening dreams		Talks in Sleep
	Walks in sleep		Grinds teeth in sleep
	Moves excessively during sleep		Has jerking of arms or legs during sleep
	Snores or has labored breathing during sleep		Stops breathing during sleep
	Wets bed during sleep		Arouses screaming in terror
	Gets out of bed and urinates on floor		Has seizures or convulsions during sleep
	Awakens at night for bathroom or diaper change		Other:
	Requires nightlight		

17. How does the child appear when getting up in the morning?

ALERT & RESTED

SLUGGISH

VERY GROGGY

18. How long does it take the child to "GET GOING" in the morning?

FEW MINUTES

30 MINUTES

AN HOUR OR MORE

19. Does the child have any complaints on waking? YES NO
    If yes, please describe:_____

20. What is the child's best time of day (when most alert)?_____

21. What is the worst time of day (when most sleepy)?_____

22. How frequently does the child take naps? _____

23. Length of nap?_____

24. How does the child appear after taking a nap?
    VERY REFRESHED SOMEWHAT REFRESHED
    SOMEWHAT TIRED VERY DROWSY

25. Have you ever noted the child to have an over-powering, irresistible attack of sleep?
    YES NO If yes, describe how frequently this occurs and in what situations._____
    _____

26. Does the child ever lose muscle strength when excited, startled, angry, or laughing?
    YES NO (for example weakness in knees, sagging facial muscles or total collapse)

27. Does the child every see or hear things that are not real as he/she goes to sleep or wakes up. YES NO

28. Do any family members have symptoms listed in the last three questions? YES NO

29. How much sleep do you think your child needs? _____

Medications:

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Name: **Dose:** **Time of Day:**