# 

Name:

First Middle Last

Sex: Male Female Date of Birth:

Mother’s Name: Father’s Name:

**Please check 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

1. Who puts the child to bed?
2. Where does the child fall asleep?

Own bed Parent’s bed Being held Rocked Fed Room other than child’s bedroom.

1. Does child need a Bottle Pacifier or Special object to fall asleep?
2. Is the child put in bed: Awake or Asleep?
3. Is there a bedtime ritual (routine)? Yes No
4. Is bedtime at a regular time every night (including weekends)? Yes No
5. Does the child use sleep medication? Yes No If yes, what?
6. Who else sleeps in the child’s room?

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 |  |

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

Alert and Rested

Sluggish

Very Groggy

1. How long does it take the child to “GET GOING” in the morning?

Few Minutes

30 Minutes

An Hour or More

1. What is the child’s best time of day (when most alert)?
2. What is the worst time of day (when most sleepy)?
3. How frequently does the child take naps?
4. Length of nap?
5. How does the child appear after taking a nap?

Very Refreshed Somewhat Refreshed

Somewhat Tired Very Drowsy

1. 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.

1. 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)
2. Does the child every see or hear things that are not real as he/she goes to sleep or wakes up?

Yes No

1. Do any family members have symptoms listed in the last three questions? Yes No
2. How much sleep do you think your child needs?

Medications:

Name: Dose: Time of Day: