Alfred I. duPont Hospital for Children
Nemours Children's Clinic

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?	
Person completing form:	Relationship to patient:

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?

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

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?

Awakens refreshed and rested	☐ Never	☐ Some mornings	☐ Most mornings	☐ Every morning
*Awakens tired and still sleepy after a full night's sleep	☐ Never	☐ Some mornings	☐ Most mornings	☐ Every morning
Awakens coughing	☐ Never	☐ Some mornings	☐ Most mornings	☐ Every morning
Awakens choking	☐ Never	☐ Some mornings	☐ Most mornings	☐ Every morning
*Awakens with a headache	☐ Never	☐ Some mornings	☐ Most mornings	☐ Every morning
Needs help to awaken	☐ Never	☐ Some mornings	☐ Most mornings	☐ Every morning

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?

	CHANCE OF DOZING			
Sitting and reading	☐ No	☐ Slight	☐ Moderate	☐ High
Watching TV	☐ No	☐ Slight	☐ Moderate	☐ High
Sitting, inactive in a public place (e.g. theatre or meeting)	☐ No	☐ Slight	☐ Moderate	☐ High
*As a passenger in a car for an hour without a break	☐ No	☐ Slight	☐ Moderate	☐ High
Lying down to rest in the afternoon when circumstances permit	☐ No	☐ Slight	☐ Moderate	☐ High
Sitting and talking to someone	☐ No	☐ Slight	☐ Moderate	☐ High
Sitting quietly after a lunch	☐ No	☐ Slight	☐ Moderate	☐ High
In a car, while stopped for a few minutes in traffic	☐ No	☐ Slight	☐ Moderate	☐ High

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:

Prescription Medication Name	How much?	How often?	Last taken?
1.			
2.			
3.			
4.			
5.			

Over-the-counter Medication Name	How much?	How often?	Last taken?
1.			
2.			
3.			
4.			

Herbal Remedy / Nutritional Supplement Name:	Last taken?
1.	
2.	
3.	

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