New Patient Sleep Questionnaire

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COMMUNITY HEALTH PARTNERS

Patient Name:_____ **Date of Birth:** _____

List any MEDICATIONS/SURGERIES you have tried to help your child with their sleep concern:

_____

_____

SLEEP SCHEDULE	Usual Bed Time	Time Falls Asleep	Usual Wake-Up Time	Any NAPS?
(School/Work Night)				
(Weekend/Vacation)				

DAYTIME SYMPTOMS	Never	Sometimes (some nights of week)	Frequently (most nights of week)
Daytime sleepiness or fatigue			
Falls asleep in school or on car rides			
Difficulty focusing/School performance problems			
Depressed mood			
Irritability/Mood swings			

CURRENT SLEEP SYMPTOMS	Never	Sometimes (some nights of week)	Frequently (most nights of week)
Snoring			
Choking/Gasping/Difficulty breathing during sleep			
Stops/Pauses in breathing during sleep			
Mouth open breathing			
Restless sleeper			
Sweaty during sleep			
Bedwetting			
Wake up with morning headaches			
Nasal congestion/Runny nose			
Wakes up feeling refreshed			
Kicks legs during sleep			
Teeth grinding			
Leg discomfort (ie. Creepy-crawly, ants crawling on leg feeling), worse in evening, better with leg movement			
Nightmares			
Sleep-walking			
Sudden awakening with screaming during sleep			
Body rocking or head banging during sleep			
Feel weakness in hands, arms, legs, neck, or face after a strong emotion like laughing, crying, anger			
Feel paralyzed while falling asleep or upon waking up			
Hallucinations while falling asleep or upon waking up			
Difficulty going to bed/Resists going to sleep			
Difficulty staying asleep			
Racing thoughts/Anxieties/Worries at bedtime			
Parent must be present for child to fall asleep			
Technology present (ie. Phone, tablet, video games)			
Caffeinated beverages within a couple hours of bedtime			

If your child is age 8 years or older, please complete this side.

Directions: Over the last MONTH, how likely have you been to fall asleep while engaged in the activities that are described below? If you haven't done some of the things in the last month, imagine how they might have affected you.

Use the following scale to choose one number that best describes what has been happening to you during each activity over the last month. Write that number next to the activity.

0 = Would **NEVER** fall asleep
1 = **SLIGHT CHANCE** of falling asleep
2 = **MODERATE CHANCE** of falling asleep
3 = **HIGH CHANCE** of falling asleep

Activity	Chance of Falling Asleep (0 – 3)
Sitting and reading	_____
Sitting and watching TV or a video	_____
Sitting in a classroom at school in the morning	_____
Sitting and riding in a car or bus for about 30 minutes	_____
Lying down to rest or nap in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly by yourself after lunch	_____
Sitting and eating a meal	_____