TMJ & Sleep Therapy Centre
Of Eastern Ontario

Pediatric Sleep Evaluation Questionnaire

This questionnaire has been compiled from multiple sources to best help us assess a pediatric patient's sleep. Please fill out all questions to the best of your knowledge. This information will become part of the medical record and is considered confidential.

Today's date: _____/_____/______
day month year

Demographic Information:

Child's Last Name: ________________________ Child's First Name: __________________________

Child's Date of Birth: _____/_____/______ Child's Age: _________ Gender: ☐ M / ☐ F
day month year

Height: ______ ft. ______ in. Weight: ___________ lbs. School Grade: ______________________

Address: ____

City: ______________________________________ Prov: __________ Postal Code: ____________

Parent Phone: (Home) ________________________ Work: _____________________________

Parent Email: ____

Physician Information:

Family Physician:

Name: ____

Address: ____

____

Phone: ____

Sleep Problems:

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

____

____

What have you previously tried to help this problem? ____

____

____

Sleep Times:

Total estimated amount of sleep on a weekday (including naps):________hours ______minutes

Usual bedtime on weekday nights: _________ usual wake time on weekday mornings: ______

Total estimated amount of sleep on a weekend day (including naps):_____hours _____minutes

Usual bedtime on weekend nights: _________ Usual wake time on weekend mornings: _______

Nap times:

Number of days each week that your child takes a nap: ___________

Nap Times (from when to when):_______________________________________

General Sleep Information:	Yes	No
Is there a regular bedtime?	☐	☐
Does the child have his/her own bedroom?	☐	☐
Does the child have his/her own bed?	☐	☐
Is there a parent present when your child falls asleep?	☐	☐
Does the child resist going to bed?	☐	☐
Does the child have difficulty falling asleep?	☐	☐
Does the child awaken during the night?	☐	☐
Is this a problem?	☐	☐
If awakening at night, does the child have difficulty returning to sleep?	☐	☐
Is the child difficult to awaken in the morning?	☐	☐
Is the child a poor sleeper?	☐	☐

Current Sleep Symptoms:

	Never	Occasionally	Frequently
Mouth breathing during sleep?	☐	☐	☐
Difficulty breathing when asleep?	☐	☐	☐
Stops breathing during sleep?	☐	☐	☐
Snores?	☐	☐	☐
Restless Sleep?	☐	☐	☐
Sweating when sleeping?	☐	☐	☐
Daytime sleepiness?	☐	☐	☐
Poor appetite?	☐	☐	☐
Nightmares?	☐	☐	☐
Sleepwalking?	☐	☐	☐
Sleep talking?	☐	☐	☐
Screaming during sleep?	☐	☐	☐
Leg kicking during sleep?	☐	☐	☐
Waking up at night?	☐	☐	☐
Getting out of bed at night?	☐	☐	☐
Trouble staying in his/her bed?	☐	☐	☐
Resistance going to bed?	☐	☐	☐
Teeth grinding?	☐	☐	☐
Uncomfortable “creepy-crawly” feeling in his/her legs?	☐	☐	☐
Bed wetting?	☐	☐	☐

Current Daytime Symptoms:

	Never	Occasionally	Frequently
Chewing with mouth open, gulping?	☐	☐	☐
Trouble getting up in the morning?	☐	☐	☐

Falls asleep at school?	☐	☐	☐
Naps after school?	☐	☐	☐
Daytime sleepiness?	☐	☐	☐
Feels weak or loses control of his/her muscles with strong emotions?	☐	☐	☐
Reports being unable to move when falling asleep or upon waking?	☐	☐	☐
Reports frightening visual images before falling asleep or upon waking?	☐	☐	☐

Family History:

Other persons living in the home: ____

Does anyone in the family have a sleep disorder? ☐ Yes ☐ No

If yes, who and what disorder? ____

Does anyone in the home smoke? ☐ Yes ☐ No

Are there pets in the home? ☐ Yes ☐ No In the child's room? ☐ Yes ☐ No

On the child's bed? ☐ Yes ☐ No

Child's Medical history	Yes	No
Frequent nasal congestion?	☐	☐
Trouble breathing through his/her nose?	☐	☐
Sinus problems?	☐	☐
Chronic bronchitis or cough?	☐	☐
Environmental allergies?	☐	☐
Asthma	☐	☐
Frequent colds or flus?	☐	☐
Frequent ear infections?	☐	☐
Frequent strep throat infections?	☐	☐
Difficulty swallowing?	☐	☐
Acid reflux (Gastroesophageal reflux)?	☐	☐
Poor or delayed growth?	☐	☐
Excessive weight?	☐	☐
Hearing problems?	☐	☐

Speech problems?	☐	☐
Vision problems?	☐	☐
Seizures / Epilepsy?	☐	☐
Morning headaches?	☐	☐
Cerebral palsy?	☐	☐
Heart disease?	☐	☐
High blood pressure?	☐	☐
Sickle cell disease?	☐	☐
Genetic disease?	☐	☐
Chromosome problem (e.g., Down's)?	☐	☐
Skeleton problem (e.g., dwarfism)?	☐	☐
Craniofacial disorder (e.gm Pierre-Robin)?	☐	☐
Thyroid problem?	☐	☐
Eczema (itchy skin)?	☐	☐
Pain?	☐	☐

If your child has long-term medical problems, list the three that you think are the most important.

1. ____

2.____

3.____

Past Surgical History:

Has your child ever had his/her tonsils removed? ☐ Yes ☐ No At what age? __________

Has your child ever had his/her adenoids removed? ☐ Yes ☐ No At what age? __________

Has your child ever had ear tubes? ☐ Yes ☐ No At what age? __________

What other surgeries has your child had (include age when surgery performed)?

____

____

Past Psychiatric History:

	Yes	No
Autism?	☐	☐
Developmental Delay?	☐	☐
Hyperactivity / ADHD?	☐	☐
Anxiety / Panic attacks?	☐	☐
Obsessive Compulsive Disorder?	☐	☐
Depression?	☐	☐
Learning Disabilities?	☐	☐
Drug use/ abuse?	☐	☐
Behavioral Disorder?	☐	☐
Psychiatric Admission?	☐	☐

Medications:

Medicine Name	Reason for taking?	Dose	How Often?

Medication Allergies: ____

Environmental Allergies: ____

The above information is accurate and complete to the best of my knowledge.

____

Parent/Legal Guardian signature