Date: _____

Pre-Sleep Study Questionnaire

CHILD'S NAME _____

What time did you your child go to bed last night? _____ ○ AM ○ PM

What time did your child get up? _____ : _____ ○ AM ○ PM

About how many hours of sleep did your child get last night? _____

Did your child take any naps today? Yes / No If yes, how long? _____ mins / hours

Will your child be taking a sleep aide tonight? Yes / No If yes, please list: _____

Has your child had any alcoholic beverages today? Yes / No If yes, what? _____

Has your child had any caffeinated beverages today? Yes / No If yes, what? _____

Has your child felt sick or had physical complaints today? Yes / No If yes, what? _____

Does your child feel better now? Yes / No / Partially

Did anything out of the ordinary happen today to your child? Yes / No If yes, what? _____

Did your child have a physically strenuous day? Yes / No

What time did your child eat their last meal? _____:___ ○ AM ○ PM

How tired does your child feel right now? ○ Not at all ○ A little ○ Quite a bit ○ Extremely

How sleepy does your child feel right now? ○ Not at all ○ A little ○ Quite a bit ○ Extremely How

awake, or alert, does your child feel right now? ○ Not at all ○ A little ○ Quite a bit ○ Extremely

Comments: _____

Name of Parent/Guardian completing form _____ Signature _____

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Sleep Study Start Time: ☐ _____AM ☐_____PM

Sleep Study Technician: _____

Signature_____