Sleep Center Questionnaire

Child's Name _____ Date of Birth _____

**Directions: Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.**

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

What things have you tried to help your child's problem?

## SLEEP HISTORY

### General Sleep

| | | |
|---|---|---|
| Does the child have a regular bedtime routine? | ☐ Yes | ☐ No |
| Does the child have his/her own bedroom? | ☐ Yes | ☐ No |
| Does the child have his/her own bed? | ☐ Yes | ☐ No |
| Is a parent present when your child falls asleep? | ☐ Yes | ☐ No |

Child usually falls asleep in…
- ☐ own room in own bed (alone)
- ☐ parents' room in own bed
- ☐ parents' room in parents' bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed
- ☐ other: _____

Child usually wakes in the morning in…
- ☐ own room in own bed (alone)
- ☐ parents' room in own bed
- ☐ parents' room in parents' bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed
- ☐ other: _____

**Weekday Sleep Schedule**

The child's usual bedtime on weekday nights _____ : _____ AM / PM

The child's usual waketime on weekday mornings _____ : _____ AM / PM

**Weekend / Vacation Sleep Schedule**

The child's usual bedtime on weekend/vacation nights _____ : _____ AM / PM

The child's usual waketime on weekend/vacation mornings _____ : _____ AM / PM

**Nap Schedule**

Number of days each week child takes a nap: 0 1 2 3 4 5 6 7

If child naps, write in usual nap time(s):

Nap 1: _____ : _____ AM / PM to _____ : _____ AM / PM

Nap 2: _____ : _____ AM / PM to _____ : _____ AM / PM

Child resists going to bed? ☐ Yes ☐ No

Child has difficulty falling asleep? ☐ Yes ☐ No

How long does it take to fall asleep? minutes / hours

Child awakens during the night? ☐ Yes ☐ No

After nighttime awakening, child has difficulty falling back to sleep? ☐ Yes ☐ No

Child is difficult to awaken in the morning? ☐ Yes ☐ No

Child is poor sleeper? ☐ Yes ☐ No

## HEALTH HISTORY

Does your child drink caffeinated beverages? (Coke, Mountain Dew, iced tea) ☐ Yes ☐ No

Does your child exercise? ☐ Yes ☐ No

Is your child exposed to cigarette smoke? ☐ Yes ☐ No

Any recent changes in family situation or stressors? ☐ Yes ☐ No

If yes, please explain: