West Ottawa Sleep Centre

Sleep Diagnostic Lab

Intake Questionnaire for Pediatrics

– Sleep Habits and Disorders

Child's First Name _____ today's date_____

Child's Last Name _____

Parent/ Guardian's Name_____

Date of Birth Year_____ Month _____ Day_____

Height _____ Weight_____ Neck size _____ Gender M / F Age _____

Please describe your main concerns or problems with your child's sleep:

Describe the usual bedtime routine:

On Weekdays

Bedtime_____ How long does it take to fall asleep_____ Wake up time _____ Total hours _____

On average, how many times a night do they wake up? _____ Are the nighttime awakenings a problem?

On Weekends

Bedtime_____ How long does it take to fall asleep_____ Wake up time _____ Total hours _____

On average, how many times a night do they wake up? _____ Are the nighttime awakenings a problem?

Does the patient have any of the following problems? (please circle YES or NO)

1) Does the patient snore? YES NO

2) Does the patient wake with trouble breathing or choking or feeling short of breath YES NO

3) Have you noticed them stop breathing during sleep? YES NO

4) Are they excessively sleepy during the day? YES NO

5) Must they nap? YES NO

If Yes how many times a week and how long are the naps? _____

6) Have they fallen asleep at school in the past 6 months? YES NO

7) Has the patient fallen asleep while in a car in the past 6 months? YES NO

8) Is their nose normally congested or blocked? YES NO

9) Have their tonsils or adenoids been removed? YES NO

IF Yes When _____

10) Do they have asthma? YES NO

11) Does the patient have leg discomfort or restlessness while trying to fall asleep? YES NO

If YES, how may nights a week does it occur? ____ nights per week.

12) Do their legs/arms twitch or jump at night? YES NO

If YES, how many nights a week does it occur? ___ nights per week.

If YES, do the movements awaken them from sleep? _____

If YES, does it interfere with their ability to fall asleep?

13) Is there a history of Anemia, depression, or diabetes? YES NO

14) Have they complained of feel totally paralyzed on awakening form sleep, or on falling asleep? YES NO

15) Have they complained of seeing or hearing things that aren't really there as they fall asleep? YES NO

16) Has the patient ever collapsed or lost muscle control in the day YES NO

17) Have they complained of waking up with a sore jaw in the morning YES NO

18) Do they grind their teeth at night? YES NO

If YES do they wear an oral appliance? YES NO

19) Do they behave in unusual ways during sleep? YES NO

(Circle all that apply: talk, yell, scream, walk, hit, punch, shake, twitch, bed wet, jump)

If YES, please describe

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20) Is there a T.V, computer, tablet, cell phone in the child's room YES NO

If Yes which ones _____

Please list all illnesses or health problems that the patient currently has:

Please list all the treatments and medications the patient currently takes

(Include oxygen, inhalers, over the counter medications)

_____

How many caffeinated beverages or energy drinks does the patient drink each day, on average?

(Pops, sodas, tea, cola Red Bull)_____

What time of the day/evening do they have their last beverage?_____

Does the patient share a room/bed or sleep alone _____

If they share, whom do they share a with _____

Do you have pets in the house? (cats or dogs) and do they sleep with the patient in their bed?

_____

Parts of this sleep study maybe video recorded.

I, _____ as parent/ guardian acknowledge and give my consent to record parts of this sleep study as deemed necessary by the night technologist.

Modified Pediatric Epworth Sleepiness Scale (Ages 6-16)

How likely are you to doze off asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you.

Using the following scale to choose the **most appropriate number** for each situation.

would **never** doze **0**

slight chance of dozing **1**

moderate chance of dozing **2**

high chance of dozing **3**

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching T.V.	0 1 2 3
Sitting, inactive in a public place (movie theater or classroom	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch	0 1 2 3
Doing homework or taking a test	0 1 2 3

Total _____/24