

Child's Sleep Habits (Preschool and School-Aged)

The following statements are about your child's sleep habits and possible difficulties with sleep. Think about the past week in your child's life when answering the questions. If last week was unusual for a specific reason (such as your child had an ear infection and did not sleep well or the TV set was broken), choose the most recent typical week. Answer **USUALLY** if something occurs **5 or more times** in a week; answer **SOMETIMES** if it occurs **2-4 times** in a week; answer **RARELY** if something occurs **never or 1 time** during a week. Also, please indicate whether or not the sleep habit is a problem by circling "Yes," "No," or "Not applicable (N/A)."

Bedtime

Write in child's bedtime: _____

	3 Usually (5-7)	2 Sometimes (2-4)	1 Rarely (0-1)	Problem?		
Child goes to bed at the same time at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child falls asleep within 20 minutes after going to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child falls asleep alone in own bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child falls asleep in parent's or sibling's bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child falls asleep with rocking or rhythmic movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child needs special object to fall asleep (doll, special blanket, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child needs parent in the room to fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child is ready to go to bed at bedtime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child resists going to bed at bedtime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child struggles at bedtime (cries, refuses to stay in bed, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child is afraid of sleeping in the dark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child is afraid of sleep alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A

Sleep Behavior

Child's usual amount of sleep each day: _____ hours and _____ minutes
(combining nighttime sleep and naps)

	3 Usually (5-7)	2 Sometimes (2-4)	1 Rarely (0-1)	Problem?		
Child sleeps too little	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child sleeps too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child sleeps the right amount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child sleeps about the same amount each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child wets the bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child talks during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child is restless and moves a lot during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child sleepwalks during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child moves to someone else's bed during the night (parent, brother, sister, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A

Sleep Behavior (continued)

	3 Usually (5-7)	2 Sometimes (2-4)	1 Rarely (0-1)	Problem?		
Child reports body pains during sleep. If so, where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child grinds teeth during sleep (your dentist may have told you this)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child snores loudly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child seems to stop breathing during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child snorts and/or gasps during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child has trouble sleeping away from home (visiting relatives, vacation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child complains about problems sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child awakens during night screaming, sweating, and inconsolable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child awakens alarmed by a frightening dream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A

Waking During the Night

	3 Usually (5-7)	2 Sometimes (2-4)	1 Rarely (0-1)	Problem?		
Child awakes once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child awakes more than once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child returns to sleep without help after waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A

Write the number of minutes a night waking usually lasts: _____

Morning Waking

Write in the time of day child usually wakes in the morning: _____

	3 Usually (5-7)	2 Sometimes (2-4)	1 Rarely (0-1)	Problem?		
Child wakes up by him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child wakes up with alarm clock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child wakes up in negative mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Adults or siblings wake up child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child has difficulty getting out of bed in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child takes a long time to become alert in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child wakes up very early in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child has a good appetite in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A

Daytime Sleepiness

	3 Usually (5-7)	2 Sometimes (2-4)	1 Rarely (0-1)	Problem?		
Child naps during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child suddenly falls asleep in the middle of active behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A
Child seems tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	N/A

During the past week, your child has appeared very sleepy or fallen asleep during the following (check all that apply):

	1 Not Sleepy	2 Very Sleepy	3 Falls Asleep
Play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Riding in car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>