Pediatric Sleep Questionnaire

Date: _____ Child's Name & Age: _____

Person completing form & relationship to patient: _____

Please rate the occurrence for your child: Always (A) Frequently (F) Occasionally (O) Never (N)

Snoring ☐
Grinds their teeth ☐
Struggles to fall asleep ☐
Wets the bed ☐
Awakens during the night ☐
Gets up to use the bathroom during the night ☐
Requires medication to help sleep ☐
Wakes up cranky ☐
Difficulty waking up in the morning ☐
Breathes loudly ☐
Moves around a lot/tosses and turns ☐
Teachers report falling asleep in class ☐

Please answer the following questions with: Yes (Y) No (N) or I don't Know (IDK)

Does your child frequently have dry lips? ☐
Is your child overweight or underweight? ☐
Does your child report headaches? ☐
Does your child fidget a lot? ☐
Does your child drink soda/energy drinks/tea/sweet tea/coffee/etc? ☐
Did your child stop growing at a normal rate at any time since birth? ☐
Was your child breastfed? If yes, for how long and was it painful? ☐
Did your child have acid reflux as a baby? ☐
Did your child use a pacifier? If yes, for how long? ☐

Lastly, have you had any other concerns about your child's sleep currently or in the past that you would like to share?

_____

_____

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_____

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