Thibodaux Regional Medical Center
SLEEP DISORDERS CENTER
604 N Acadia Road, Suite 210
Thibodaux, Louisiana 70301
(985) 493-4759
Fax (985) 449-2525

PEDIATRIC QUESTIONNAIRE

Date:__________________

Child's Name:____
(First) (Middle) (Last)

Date of Birth:_________________________ Height______________ Weight_________
Social Security#______________________
Parents name or guardian:____
Address:____
____
Phone (Home):_______________________ Cell/Work ___________________________

In case of emergency contact:____

****

Insurance company_____________________ Phone # of insurance co.______________
Is Policy Private or Group?______________ Policy Number ______________________
Subscriber___________________________ Group Number _____________________
Employer name_______________________

****

Was this a self referral or physician referral?_____________________________________
If physician referral, physician's name:____
How did you first hear about our Sleep Disorder Center?__________________________

****

1. Please describe in your own words, as briefly as possible, your child's main problem.____
____

2. When was the very first time this problem began?____________________________

3. List any medications that your child is currently taking to help with sleep problems.

Medication	**Dose**	**Time**
____________________	________________	____________________________
____________________	________________	____________________________
____________________	________________	____________________________
____________________	________________	____________________________
____________________	________________	____________________________

4. Describe what your child usually does during the last 30 minutes before bedtime.
____
____

5. Does your child do any of the following in bed at night?

Read	yes/no
Watch TV	yes/no
Listen to radio	yes/no

Other;____
____

6. Will your child fall asleep alone in bed? Yes/no

7. In order to sleep, does your child often need a special toy or object? Yes/no

8. Does your child often need a bottle in order to go to sleep? Yes/no

9. What type of bed does your child sleep in?
Crib/ Single bed/ Double bed/ Other:___________________________

10. Does your child sleep alone? Yes/no
if not, who with?____

11. Which side of the body does your child sleep on?
Left side/ right side/ back/ face down

12. What time is the bedroom light turned off? _______________________AM/PM

13. Does a parent or a child turn off the light? Parent/ child

14. Is your child bothered by environmental noises at night? Yes/no

15 As an infant, was your child "colicky"? Yes/no

16. As an infant, did you child require any of the following devices to get to sleep?
    Swing/ Snuggly/ Car ride/ Being held/ Rocked/ Other ______________________

17. On average how long does it take your child to fall asleep?________hrs. ______mins.

18. What is the quickest time it has taken your child to fall asleep in the last 2 weeks?
    __________hr. ________mins.

19. What is the longest time it has taken your child to fall asleep?______hrs._______min

20. What do you think prevents your child from falling asleep?
    Fears/ loneliness/ not sleepy/ worries/ other________________________________

21. Do you get annoyed/ angry when your child cannot sleep? Yes/no

22. How often does your child cry himself/herself to sleep? __________times a week

23. Do you ever let your child cry in bed in order to get to sleep? Yes/no
    If so, how long do you let the child cry? 10/20/30 minutes/ as long as it takes

24. When unable to fall asleep, does your child get out of bed? Yes/no
    If so, how long after getting into bed? ______hrs.________mins.

25. Once out of bed, what does your child do?_____________________________
____
____

26. How long is your child up for? ________hrs.______________mins

27. When your child returns to bed, how long does it take to fall asleep again?
    ________hrs._____________mins

28. If the child does not get out of bed, how long does it take to fall back asleep?
    ________hrs.___________mins

29. Once having fallen asleep, how long does your child sleep for?
    ________hrs___________mins

30. Does you child awaken during the night? Yes/no
    If so, on average how long will your child be awake for?________hrs_______min

31. How often does your child awaken during the night?______________times

32. What time does your child finally awaken in the morning?______________A.M

33. What time does your child get out of bed in the morning? ______________A.M

34. How does your child seem on awakening in the morning?______________________
____
____

35. How does a poor nights sleep affect your child the next day?____________________
____
____

36. Does your child feel sleepy during the day? Yes/no

37. Does your child nap during the day? Yes/no
If so, for how long? _______________hrs. ______________min

38. What time of day does your child nap? _______________hrs_ _____________min

39. If there are not naps, what time of day does your child feel most tired? ____AM___PM

40. What time of day does your child seem more alert? ______AM______PM

41. As the sleep period approaches, does your child become more alert? Yes/No

42. Do you think a poor night's sleep affects your child's school performance? Yes/no

43. Has the teacher commented on this? Yes/no

44. Does your child toss and turn in bed? Yes/no

45. Have you ever noticed your child's head rocking from side to side at night? Yes/no
If so, please describe.____
____
____

46. How often does this behavior occur? _________________times

47. What time of night is this activity likely to occur?______________AM/PM

48. Does your child complain of aching legs at bedtime? Yes/no

49. Does your child move his/her legs around I bed at night? Yes/no

50. Do your child's legs jerk while he is asleep at night? Yes/no

51. Does your child have nightmares? Yes/no
If so, at what age did they begin? ___________years
How often do they occur? ___________Times

52. Does your child ever awaken suddenly with a scream and appear inconsolable?
Yes/no If so, how ofter?_____________times a month

53. Does your child sleep walk? Yes/no
If so, how often? _______________times a month

54. If your child sleep walks, has he ever injured himself? Yes/no

55. Does your child ever wet the bed? Yes/no
If so, how often ________________times per week

56. Does your child snore at night? Yes/no

57. Does the snoring occur every night? Yes/no
If so, how often _______________times per week

58. Does you child ever appear to stop breathing while asleep? Yes/no
If so, how often ______________seconds

59. Has your child ever had a tonsillectomy or adenoidectomy? Yes/no
If so, please give the date.

60. Please state when your child was last able to sleep consistently without any problems.
Never/______________years/months ago.

61. At what time would you like your child to fall asleep? ____________PM

62. How long would you like your child to sleep for? ___________hrs.

63. What time would you like your child to awaken in the morning?___________AM

64. How long do you think normal children of your child's age sleep?_________hrs.

65. Do you consider your child's sleep problem to be:
Mild / Moderate / Severe

66. Please add any other comments about your child's sleep problem that you think are relevant:____
____
____
____

67. Please list all people whom you have consulted about your child's sleep problem.
List all treatments and outcome of treatments.
____
____
____

68. Please list any operations your child may have had.

____
____
____

70. Please give the following family information:

	Age	Illnesses
Mother	___________	________________________________
Father	___________	________________________________
Brothers:		
___________	___________	________________________________
___________	___________	________________________________
___________	___________	________________________________
Sisters:		
___________	___________	________________________________
___________	___________	________________________________
___________	___________	________________________________

71. Please list any illnesses that run in the family, such as diabetes, hypertension, heart disease, psychiatric disorders, etc.

Condition:	Family Member:	Treatment:
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________