THIBODAUX REGIONAL
SLEEP DISORDERS CENTER

604 N Acadia Road, Suite 210
Thibodaux, Louisiana 70301
(985) 493-4759
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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:_____

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Insurance company_____ Phone # of insurance co._____
Is Policy Private or Group?_____ Policy Number _____
Subscriber_____ Group Number _____
Employer name_____

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

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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:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____