Valley Sleep Center
A Night and Day Difference!

PHONE: (480) 830-3900
FAX: (480) 830-3901
valleysleepcenter.com

ACCREDITED FACILITY MEMBER

PEDIATRIC SLEEP EVALUATION

Directions:

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

CHILD'S INFORMATION

Child's name: _____

Child's age: _____

What are your major concerns about your child's sleep?

How long has this concern been present? _____

What things have you tried (if any) to help your child's problem?

SLEEP HISTORY

SLEEP SCHEDULE

Weekday Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period on **weekdays:** _____ hours _____ minutes
(add daytime and nighttime sleep)

The child's usual **bedtime** on **weekday nights:** _____

The child's usual **waketime** on **weekday mornings:** _____

Does he/she wake on own or need to be woken? ☐ wakes on own ☐ needs to be woken

Weekend/Vacation Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period during **weekends** and **vacations:** _____ hours _____ minutes
(add daytime and nighttime sleep)

The child's usual **bedtime** on **weekend/vacation nights:** _____

The child's usual **waketime** on **weekend/vacation mornings:** _____

Does he/she wake on own or need to be woken? ☐ wakes on own ☐ needs to be woken

Nap Schedule

Number of days each week child takes a nap: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

If child naps, write in usual nap time(s):

Nap 1: _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m.

Nap 2: _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m.

NIGHTTIME SYMPTOMS

Does your child have any of the following during the **night?**

☐ Snoring

☐ Stops breathing during sleep

☐ Gasping or choking during sleep

☐ Grinds his/her teeth during sleep

☐ Kicks legs in sleep

☐ Uncomfortable feeling in his/her legs; creepy-crawly feeling

☐ Reports unable to move when falling asleep or upon waking

DAYTIME SYMPTOMS

Does your child have any of the following during the **day?**

☐ Attention difficulties

☐ Behavior difficulties

☐ Learning difficulties

☐ Feels weak or loses control of his/her muscles with strong emotion (for example, laughter)

☐ Daytime sleepiness (if yes, please help your child fill out the following sleepiness scale)

EPWORTH SLEEPINESS SCALE – CHILDREN

How likely are you to doze off or fall 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 have affected you. **Choose the most appropriate number for each situation.**

0 = Would never fall asleep **1** = Slight chance of dozing **2** = Moderate chance of dozing **3** = High chance of dozing

Situation	**Chance of Dozing**			
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (for example, a 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 0 _____

MEDICAL AND PSYCHIATRIC HISTORY

MEDICAL HISTORY

Frequent nasal congestion	☐ Yes	Age of diagnosis: _____
Trouble breathing through his/her nose	☐ Yes	Age of diagnosis: _____
Sinus problems	☐ Yes	Age of diagnosis: _____
Chronic bronchitis or cough	☐ Yes	Age of diagnosis: _____
Asthma	☐ Yes	Age of diagnosis: _____
Frequent colds or flus	☐ Yes	Age of diagnosis: _____
Frequent ear infections	☐ Yes	Age of diagnosis: _____
Frequent strep throat infections	☐ Yes	Age of diagnosis: _____
Difficulty swallowing	☐ Yes	Age of diagnosis: _____
Acid reflux (gastroesophageal reflux)	☐ Yes	Age of diagnosis: _____
Poor or delayed growth	☐ Yes	Age of diagnosis: _____
Excessive weight	☐ Yes	Age of diagnosis: _____
Hearing problems	☐ Yes	Age of diagnosis: _____
Speech problems	☐ Yes	Age of diagnosis: _____
Vision problems	☐ Yes	Age of diagnosis: _____
Seizures/Epilepsy	☐ Yes	Age of diagnosis: _____
Morning headaches	☐ Yes	Age of diagnosis: _____
Cerebral palsy	☐ Yes	Age of diagnosis: _____
Heart disease	☐ Yes	Age of diagnosis: _____
High blood pressure	☐ Yes	Age of diagnosis: _____
Sickle cell disease	☐ Yes	Age of diagnosis: _____
Genetic disease	☐ Yes	Age of diagnosis: _____
Chromosome problem (e.g., Down's)	☐ Yes	Age of diagnosis: _____
Skeleton problem (e.g., dwarfism)	☐ Yes	Age of diagnosis: _____
Cranofacial disorder (e.g., Pierre-Robin)	☐ Yes	Age of diagnosis: _____
Thyroid problems	☐ Yes	Age of diagnosis: _____
Eczema (itchy skin)	☐ Yes	Age of diagnosis: _____
Pain	☐ Yes	Age of diagnosis: _____
Allergies	☐ Yes	Age of diagnosis: _____

Please list allergies:

PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Autism	☐ Yes	Age of diagnosis: _____
Developmental delay	☐ Yes	Age of diagnosis: _____
Hyperactivity/ADHD	☐ Yes	Age of diagnosis: _____
Anxiety/panic attacks	☐ Yes	Age of diagnosis: _____
Obsessive Compulsive Disorder	☐ Yes	Age of diagnosis: _____
Depression	☐ Yes	Age of diagnosis: _____
Suicide	☐ Yes	Age of diagnosis: _____
Learning disability	☐ Yes	Age of diagnosis: _____
Drug use/abuse	☐ Yes	Age of diagnosis: _____
Behavioral disorder	☐ Yes	Age of diagnosis: _____
Psychiatric admission	☐ Yes	Age of diagnosis: _____

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/ psychologist.

CURRENT MEDICATIONS

Please list any medications your child currently takes:

	Medicine	**Dose**	**How often?**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Allergies to medications (if any): _____

MEDICAL PROBLEMS

If your child has medical problems, please list the three you think are most important.

1. _____
2. _____
3. _____

SURGERIES/HOSPITALIZATIONS

Has your child ever had his/her tonsils removed? ☐ Yes Age of surgery: _____

Has your child ever had his/her adenoids removed? ☐ Yes Age of surgery: _____

Has your child ever had ear tubes? ☐ Yes Age of surgery: _____

Please list any additional hospitalizations or surgeries:

1. _____

2. _____

3. _____

PREGNANCY/ DELIVERY

Pregnancy ☐ Normal ☐ Difficult

Delivery ☐ Term ☐ Pre-term ☐ Post-term

Child's birthweight: _____

Only child? ☐ Yes ☐ No If no, check birth order: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th

HEALTH HABITS

Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)

☐ No ☐ Yes Amount per day: _____

FAMILY SLEEP HISTORY

Does anyone in the family have a sleep disorder? ☐ Yes ☐ No

If yes, mark the disorder(s):

Insomnia	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent

Other: _____

SOCIAL HISTORY

SCHOOL PERFORMANCE

Your child's grade: _____

Has your child ever repeated a grade? ☐ No ☐ Yes

Is your child enrolled in any special education class? ☐ No ☐ Yes

How many school days has your child missed so far this year? _____

How many school days did your child miss last year? _____

How many school days was your child late so far this year? _____

How many school days was your child late last year? _____

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

PERSONS LIVING IN HOME

	Name:	Relationship:	Age:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

REFERRING PHYSICIAN

Who asked that your child be seen by a sleep specialist?

☐ Pediatrician

☐ Child's parent or guardian

☐ Surgical specialist (e.g., ENT)

☐ Pediatric specialist (e.g., allergist, neurologist, pulmonologist)

☐ Mental health specialist (e.g. psychiatrist, psychologist, social worker)

☐ Schoolteacher/nurse

☐ Child himself/herself

☐ Other: _____