

Appendix E.16 Child Sleep Habits Questionnaire

Form Approved

OMB NO. _____

Exp. Date _____

Public Reporting Burden Statement

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

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

Coding

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