Sleep Questionnaire

How likely is your child/teen to doze off or fall asleep in the following situations, in contrast to just feeling tired?

Situation	0- Least Likely 3- Most Likely			
Sitting and reading	0	1	2	3
Sitting and watching TV or a video	0	1	2	3
Sitting in a classroom at school during the morning	0	1	2	3
Sitting and riding in a car or a bus for about half an hour	0	1	2	3
Lying down to rest or nap in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly by yourself after lunch	0	1	2	3
Sitting and eating a meal	0	1	2	3

Please total your score. Total=_____

1. Do you feel your child/teen's work, home, or social life is negatively affected by the above?	**Yes No**
2. Does your child/teen feel tired or sleepy when you need to be awake?	**Yes No**
3. Does your child/teen snore loudly on most nights?	**Yes No**
4. Does your child/teen have morning headaches?	**Yes No**
5. Does anyone in your family snore loudly or have sleep apnea?	**Yes No**
6. Does your child/teen sleep walk?	**Yes No**
7. Does your child/teen have creepy, crawly, legs at night that keep them awake on most nights of the week?	**Yes No**
8. Does your child/teen have "sleep attacks" during the day while laughing or experiencing strong emotions?	**Yes No**

What is your child/teen's usual sleep schedule:

What time do they go to sleep on a typical school day?_____

What time do they awaken on a typical school/work day?_____

NAME: _____ DATE: _____