CHILDREN’S NATIONAL MEDICAL CENTER
PEDIATRIC SLEEP DISORDERS PROGRAM

Dear Parent:

Your child ___________________________, has an appointment at the Children’s National Pediatric Sleep Disorders Clinic on _________________ at ___________. Please plan to arrive at least 15 minutes before your scheduled appointment time.

Your sleep medicine clinic appointment will be located at one of our two centers:

**Children’s National Medical Center Locations**

<table>
<thead>
<tr>
<th>Washington DC Location:</th>
<th>Rockville Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary &amp; Sleep Medicine Clinic, Suite 1030</td>
<td>Pulmonary Medicine Department, 4th Floor</td>
</tr>
<tr>
<td>111 Michigan Ave NW</td>
<td>9850 Key West Avenue</td>
</tr>
<tr>
<td>Washington DC, 20010</td>
<td>Rockville, Maryland 20850</td>
</tr>
</tbody>
</table>

You and your child will be seen by our Pediatric Sleep Team. Initial appointments typically last 1 1/2- to 2 hours.

Please complete this intake package **before** your appointment. Note that the first page of this intake is a two-week sleep log. We would also like this filled out before your appointment. Please fill out the forms with your child and bring completed form to your next appointment.

We look forward to meeting you and your child. Please feel free to call us with any questions at **202-476-2128**.

Because there is a long wait list for new Sleep Clinic appointments, **please call us at 202-476-4490 at least 48 hours in advance if you need to cancel or reschedule your appointment.**

We look forward to meeting you,

Gustavo NinoBarrera MD, MSc, D’ABSM
Director of Sleep Medicine
Sleep Medicine Physician & Pulmonologist

Daniel Lewin PhD, D’ABSM, C.BSM
Associate Director of Sleep
Clinical Psychologist

Jenny Lew, MD, D’ABSM
Sleep Medicine Physician & Pulmonologist

Miriam Weiss, CPNP, CCSH, MSN
Program Coordinator
Nurse Practitioner

Iman Sami-Zakhari, MD, D’ABSM
Sleep Medicine Physician & Pulmonologist
Two-Week Sleep Record

Date of Sleep Record: From _________ To__________

The purpose of this sleep log is to track your child’s sleep at home. For the next two weeks, mark the time your child goes to bed or wakes up (with ↑ or ↓ as indicated in the key) and shade in the blocks your child is sleeping including naps.

Key:

↓: Going to Sleep/ Bedtime  □: Awake (non-shaded block)  F: Breast/Bottle Feeding

↑: Waking Up/ Night Waking  ➳: Asleep (shaded block)

| Day (Date) | 12a | 1a  | 2a  | 3a  | 4a  | 5a  | 6a  | 7a  | 8a  | 9a  | 10a | 11a | 12p | 1p  | 2p  | 3p  | 4p  | 5p  | 6p  | 7p  | 8p  | 9p  | 10p | 11p |
|------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Example:   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| Mon (1/3)  | S   | L   | E   | E   | P   | F   | ↑   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |

↓ Midnight

↓ Noon
The following questions are about your child’s sleep habits and sleep problems. Please answer all questions:

Child’s Name: ____________________________     Today’s Date: ______ / ______ / ______

Child’s Gender: □ Male □ Female   Child’s Age: ___________  Child’s Date of Birth: ______ / ______ / ______
□ Other (please specify): ______________________________

Caregiver #1: ____________________________________________  □ Currently filling out form
Caregiver #1 Gender: □ Male □ Female □ Other (please specify): ______________________________
Caregiver #1 Relationship to the Child: ______________________________________________________

Caregiver #2: ____________________________________________  □ Currently filling out form
Caregiver #2 Gender: □ Male □ Female □ Other (please specify): ______________________________
Caregiver #2 Relationship to the Child: ______________________________________________________

Referral by: ____________________________________________

Pediatrician: ____________________________________________

A copy of the sleep clinic evaluation report will be sent to your pediatrician and any referring physician. Please indicate anyone else who should receive a copy:

Name: _________________________________________________________________________________________

Address: ___________________________________________________________________________________________

Please list all members of the household in which your child sleeps most of the time:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to Child</th>
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Does your child regularly sleep in another household?  □ Yes  □ No
If yes, on average, how many nights per month? ____________________________

Please list all members of the other household in which your child regularly sleeps:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to Child</th>
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</tbody>
</table>

Please list family members (parents, grandparents, siblings) with a history of any SLEEP PROBLEMS (including: loud snoring/obstructive sleep apnea, excessive sleepiness/narcolepsy, restless legs/periodic leg movement, insomnia, other sleep problems).

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Type of Sleep Problem</th>
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<tbody>
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</table>
Please list any family members with a history of mental health problems (such as depression, ADHD, anxiety, alcoholism/substance abuse).

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Type of Mental Health Problem</th>
</tr>
</thead>
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Questions 1-4, refers to Caregiver #1

1. Marital status: □ Married   □ Divorced/Separated   □ Widowed   □ Single   □ Living with partner
   If divorced, shares child custody with: ______________________________________

2. Highest level of education: ______________________________________

3. Occupation: _______________________________________________________________________________________

4. Caregiver #1 work outside of home?  □ Yes   □ No
   If yes, mark any labels that best describe the work schedule:
   □ Day shift   □ Full time   □ Evening shift   □ Overnight shift   □ Part time

Questions 5-8, refers to Caregiver #2

5. Marital status: □ Married   □ Divorced/Separated   □ Widowed   □ Single   □ Living with partner
   If divorced, shares child custody with: ________________________________

6. Highest level of education: ______________________________________

7. Occupation: _______________________________________________________________________________________

8. Caregiver #2 work outside of home?  □ Yes   □ No
   If yes, mark any labels that best describe the work schedule:
   □ Day shift   □ Full time   □ Evening shift   □ Overnight shift   □ Part time

BACKGROUND:

9. What best describes your child’s ethnic background?  □ Hispanic or Latino   □ Not Hispanic or Latino

10. What best describes your child’s racial background? Check all that apply:
    □ White/Caucasian   □ Asian   □ Black/African American   □ American Indian or Alaska Native
    □ Native Hawaiian or other Pacific Islander   □ Multiracial (Please specify) _____________________________
    □ Other (Please specify): ______________________________________

HEALTH HISTORY

BIRTH HISTORY:

11. Did you or your doctor note any problems with the pregnancy of this child? (e.g.: drug/alcohol abuse, cigarette use, high blood pressure)
   ______________________________________

12. Child was born at ______ weeks gestation.

13. Please list any complications in the newborn period: (ex: NICU stay?  Sent home with apnea monitor?)
   ______________________________________
   ______________________________________

MENTAL HEALTH HISTORY:

14. Has your child ever received treatment for behavioral or mental health problems?
    □ Yes   □ No
    If yes, when and for what reason? ______________________________________

    If so, name of provider or agency: ______________________________________
MEDICAL HISTORY:

15. Does your child have a history of developmental problems? □Yes □ No
   If yes, please list:
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________

16. Does your child have a history of health problems? □Yes □ No
   If yes, please list:
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________

17. Does your child currently have any health problems? □Yes □ No
   If so, please describe:
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________

18. Does your child currently have: Check all that apply: □
   □Oxygen therapy □ CPAP/BiPAP □ Tracheostomy

19. Has your child ever been hospitalized overnight? □Yes □ No
   If yes, please list approximate dates and reason for hospitalization:
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________

20. Have your child’s tonsils and/or adenoids been removed? □Yes □ No
   If yes, circle which one or if both apply: Tonsils / Adenoids Date(s): ______________________________
   For what reason:
   ____________________________________________________________________________________________
   Describe briefly any changes you noticed in your child’s sleep or waking behavior after removal of tonsils and/or adenoids:
   ____________________________________________________________________________________________

21. Has your child ever had an operation (other than removal of tonsils and adenoids)? □Yes □ No
   If yes, please list type/date(s):
   ____________________________________________________________________________________________

22. Has your child ever had a head injury/concussion requiring medical evaluation? □Yes □ No
   If yes, please list date(s) and briefly describe:
   ____________________________________________________________________________________________

23. Has your child ever had a serious injury (other than head injury) requiring medical evaluation? □Yes □ No
   If yes, please list type/date(s):
   ____________________________________________________________________________________________
Has your child had or currently has any of the following: (Check all that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>In Past 12 Months</th>
<th>At Any Time in the Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Broken bones (nose/face)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>B. Nasal congestion/difficulty breathing through nose</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C. Frequent strep throat/tonsillitis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>D. Frequent ear infections</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>E. Frequent colds/respiratory infections like bronchitis</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>F. Frequent sinus infections</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>G. Allergies – Environmental or Food:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If yes, to what: __________________________</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>H. Asthma</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I. Other respiratory problems (Please specify): _________________________</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>J. Eczema/Skin Allergies</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>K. Frequent heartburn</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>L. Diagnosed acid (gastroesophageal) reflux</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>M. Poor or slow growth</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>N. Overweight/obesity</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>O. Seizures/convulsions</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>P. Frequent and/or severe headaches</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Q. Thyroid problems</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

24. Does your child have medication allergies?  ☐ Yes  ☐ No
   If yes please list:
   ________________________________________________________________
   ________________________________________________________________

25. List any prescription or over-the-counter medications your child has taken in the last month: Including TABLETS, CAPSULES, LIQUIDS, CREAMS, NASAL SPRAYS, INHALERS, NEBULIZED MEDICATIONS,
   Type _________________________________ Reason for medication: _________________________________
   Type _________________________________ Reason for medication: _________________________________
   Type _________________________________ Reason for medication: _________________________________
26. Has your child ever been diagnosed with a sleep disorder? □ Yes □ No (if yes please specify):
□ Narcolepsy □ Obstructive Sleep Apnea □ Restless Leg Syndrome □ Insomnia
Other: ____________________________________________________________

27. What are you major concerns about your child's sleep?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

28. How long has your child had difficulty with sleep?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

29. What do you think is causing your child’s sleep problems?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

30. Why are you seeking an evaluation for your child’s sleep problem?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

31. What are your goals for this evaluation?
________________________________________________________________________
________________________________________________________________________
Questions 32-41 refer to child’s sleep during the last 1 month on **School Nights**:

**School Nights are considered:**

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
</tr>
</thead>
<tbody>
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<td>![Sleep Icon]</td>
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</tr>
</tbody>
</table>

32. What time does your child go to bed at night?  ____________ PM/AM

33. How much does your child’s bedtime and wake up time change from day to day for school nights?
   - □ Less than 15 min.
   - □ 15 to 30 min.
   - □ 30 to 60 min.
   - □ More than 60 min.

34. How often does your child have difficulty falling asleep at night out of 5 nights?
   - □ Never
   - □ Not during the past month
   - □ Less than once a week
   - □ 1-2 times a week
   - □ 3-4 times a week
   - □ 5 or more times a week

   34a. How much time does it usually take your child to fall asleep after going to bed?  ____________ Hrs. ________ Min.

   34b. What is the longest time it has taken your child to fall asleep after being put to bed?  ____________ Hrs. ________ Min.

35. How many times per night does your child wake up in the middle of the night and take 10 or more minutes to fall back to sleep?
   - □ Once
   - □ Twice
   - □ 3 times or more
   - □ None

   35a. How often do night wakings occur?
   - □ Never
   - □ Not during the past month
   - □ Less than once a week
   - □ 1-2 times a week
   - □ 3-4 times a week
   - □ 5 or more times a week

   35b. How much time does it usually take her/him to fall back to sleep after waking in the night?  ______ Hrs. ______ Min.

36. On average, how many hours does your child sleep on school nights?  ____________ Hrs.

37. What time does your child wake up on school mornings?  ____________ AM/PM

38. What time does your child’s school start?  ____________ AM/PM

39. On how many school mornings does your child:
   - a. Wake up on her/his own?  0 1 2 3 4 5
   - b. Use an alarm to wake up?  0 1 2 3 4 5
   - c. Is awakened by a parent, sibling or other caretaker?  0 1 2 3 4 5
   - d. Need to be awakened several times before getting out of bed?  0 1 2 3 4 5

40. How often does your child have difficulty waking up in the morning?
   - □ 1-2 days
   - □ 2-3 days
   - □ 4-5 days
   - □ None

41. Does your child nap?  □ Yes  □ No

   41a. How often does your child nap?  □ Once a day  □ More than once a day  □ Never

   41b. How many days does your child nap during the weekday?  1 2 3 4 5

   41c. If your child naps on the weekday, how long is a typical nap?  ______ Hrs. ________ Min.

   41d. What time(s) does your child nap?  ________________ PM/AM  TO  ________________ PM/AM
Questions 42-59 refer to child’s sleep during the last 1 month on **Weekend/Vacation Nights:**

**Weekend Nights are considered:**

<table>
<thead>
<tr>
<th>Friday</th>
<th>Saturday</th>
</tr>
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<tbody>
<tr>
<td>![Sleep icon]</td>
<td>![Sleep icon]</td>
</tr>
</tbody>
</table>

42. What time does your child go to bed at night? ________ PM/AM

43. How often does your child have difficulty falling asleep at night?

   - □ Never
   - □ Not during the past month
   - □ One Night
   - □ Both Nights

43a. How much time does it usually take your child to fall asleep after going to bed? ________ Hrs. _______ Min.

43b. What is the longest time it has taken your child to fall asleep after being put to bed? ________ Hrs. _______ Min.

44. How many times per night does your child wake up in the middle of the night and take 10 or more minutes to fall back to sleep?

   - □ Once
   - □ Twice
   - □ 3 times or more
   - □ None

44a. How often does your child have night wakings?

   - □ Never
   - □ Not during the past month
   - □ One Night
   - □ Both Nights

44b. How much time does it usually take her/him to fall back to sleep after waking in the night? ________ Hrs. _______ Min.

45. What time does your child wake up in the morning? ________ PM/AM

46. Do you wake your child in the mornings?

   - □ Never
   - □ Sometimes
   - □ Always

47. How often does your child have difficulty waking up?

   - □ Never
   - □ Not during the past month
   - □ One Night
   - □ Both Nights

48. Does your child nap during the weekend? □ Yes □ No

48a. How often does your child nap?

   - □ Once a day
   - □ More than once a day
   - □ Never

48b. How many days does your child nap?

   - □ 1 day
   - □ Both days
   - □ None

48c. If your child naps, how long is a typical nap? ________ Hrs. ________ Min.

48d. What time(s) does your child nap?

   - ________ PM/AM TO ________ PM/AM

49. On average, how many hours does your child sleep on weekend nights? ________ Hrs.
General Sleep Questions

50. If your child set his/her own schedule, which would s/he prefer?
  □ Go to bed early and wake up early  □ Go to bed late and wake up late  □ No preference

51. How much sleep do you think your child needs? _________Hrs. _________Min.

52. Which of the following does your child have in her/his bedroom? (please check all that apply):
  □ TV/DVD  □ Computer/Tablet  □ Video Game System  □ Cellular Phone

53. Has your child ever taken over-the-counter or prescription medications at bedtime to help her/him calm down in the evening and/or fall asleep? □ Yes □ No
  If yes, please list the medications and dose: ________________________________

54. Does your child drink caffeinated beverages (for example, colas, iced tea, Mountain Dew, energy drinks, Sunkist, chocolate milk) or eat foods that contain caffeine (for example, chocolate)? □ Yes □ No
  If yes, please check one:
  □ Never  □ Not during the past month  □ Less than once a week  □ 1-2 times a week  □ 3-4 times a week  □ 5 or more times a week

Below is a list of questions about various sleep problems. For each question please think about the last month. Please answer all items the best you can, even if some of these questions do not apply to your child.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>1 or 2 times a week</th>
<th>3 or 4 times a week</th>
<th>5 or more times a week</th>
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</thead>
<tbody>
<tr>
<td>55 How often is there a <strong>regular bedtime routine</strong> in your home?</td>
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<tr>
<td>56. How often does your child <strong>share a bedroom</strong> with another family member?</td>
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<td>57. How often does your child <strong>sleep in a caretaker’s bed</strong>?</td>
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<td>58. How often does your child <strong>resist going to bed</strong>?</td>
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<td>59. How often is bedtime and the hour leading up to it a <strong>stressful time</strong>?</td>
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<td>60. After bedtime, how often does your child <strong>call you back</strong> to the bedroom more than 2 times?</td>
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<td>61. Does your child have uncomfortable feelings in the legs or arms (occurring at bed time or when sitting for a long time) that are relieved by movement or rubbing? Please check one: □ Yes □ No</td>
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<td>62. How often do you observe your child while s/he sleeps?</td>
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<tr>
<td>63. How often does your child snore?</td>
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<tr>
<td>63a. If your child snores, it can be heard…. Please check one:</td>
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<td>64. While your child is sleeping, does s/he have any breathing problems? Please check all that apply: □ struggles to breath □ gasps □ holds her/his breath □ stops breathing for short periods of time</td>
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<tr>
<td>Question</td>
<td>Never</td>
<td>Not during the past month</td>
<td>Less than once a week</td>
<td>1 or 2 times a week</td>
<td>3 or 4 times a week</td>
<td>5 or more times a week</td>
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<tr>
<td>64a. If yes, how often do these breathing problems occur?</td>
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<tr>
<td>65. How often does your child grind her/his teeth while sleeping?</td>
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<td>66. How often is your child a restless sleeper?</td>
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<td>67. How often does your child wet her/his bed at night?</td>
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<tr>
<td>67a. If your child wets the bed has s/he ever been completely dry for more than one week?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>68. How often does your child report having nightmares or frightening dreams?</td>
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<tr>
<td>69. How often does your child wake up during the night screaming, agitated or confused?</td>
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</tr>
<tr>
<td>69a. If yes, does s/he calm down after being comforted? Please check one:</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Please provide any specific details:</td>
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<tr>
<td>69b. If yes, does s/he remember waking up the next morning?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>70. How often does your child sleep walk?</td>
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<tr>
<td>70a. While sleepwalking has s/he ever: Please check all that apply:</td>
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<td></td>
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<tr>
<td>□ been at risk of injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>□ been injured</td>
<td></td>
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<tr>
<td>□ attempted to leave the bedroom</td>
<td></td>
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<tr>
<td>71. Does your child have repetitive movements during sleep? For example (please check all that apply):</td>
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<tr>
<td>□ leg jerks □ head banging □ lip smacking □ other (please specify):</td>
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<td></td>
</tr>
<tr>
<td>72. How often does your child fall asleep suddenly at unexpected times?</td>
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<tr>
<td>73. How often does your child report having very real dreams that there is a person or animal in her/his room?</td>
<td></td>
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<tr>
<td>74. How often has your child experienced sudden muscle weakness including weak knees/buckling of the knees and sagging of the jaw during emotions like laughing, happiness, or anger?</td>
<td></td>
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</tr>
</tbody>
</table>
Please rate your child’s chances of falling asleep or dozing in each of the situations listed below. Think about a typical day:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Would never doze</th>
<th>Slight chance of dozing</th>
<th>Moderate chance of dozing</th>
<th>High chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Sitting and Reading</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Watching TV</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Sitting quietly in public (in movie/ school)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Riding in a car or on a bus</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Lying down to rest in the afternoon</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>f. While sitting and talking to someone</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>g. While sitting or playing quietly after lunch</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>h. While doing homework or reading</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

How concerned are you about your child’s sleep problem? Please circle a number on the scale below.

0 1 2 3 4 5 6 7 8 9 10

Not Concerned  Moderately Concerned  Extremely Concerned

Do you have additional comments about your child’s sleep or health?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

THANK YOU!