

8-17 yrs

1. Who in your family sets the rules about when you go to bed?
 Mom Dad You Other: _____
2. Do you think you have trouble sleeping? Yes No
3. Do you like to go to sleep? Yes No

	Usually (5-7)/ week	Sometimes (2-4)/ week	Rarely (0-1)/ week or never
4. Do you get to bed at the same time every night on school nights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you fall asleep in the same bed every night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you fall asleep alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you fall asleep in your parent's, brother's, or sister's bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you fall asleep in about 20 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you fight with your parents about going to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is it hard for you to go to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you ready for bed at your usual bedtime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a special thing (doll, blanket, etc.) you bring to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you afraid of the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you afraid of sleeping alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you stay up late when your parents think you are asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Sleep Behavior

- 16. Do you think you sleep too little? Yes No
- 17. Do you think you sleep too much? Yes No
- 18. Do you wake up at night when your parents think you're asleep? Yes No
- 19. Do you have trouble falling back to sleep if you wake up during the night? Yes No
- 20. Do you have nightmares? Yes No
- 21. Does pain wake you up at night?
Where is that pain? Yes No
- 22. Do you sometimes go to someone's bed during the night?
If yes, whose? Yes No

Usually (5-7)/week **Sometimes (2-4)/week** **Rarely (0-1)/week or never**

Daytime Sleepiness

- 23. Do you have trouble waking in the morning?
- 24. Do you feel sleepy during the day?
- 25. Do you take naps during the day?
- 26. Do you feel rested after a night's sleep?

Morning Waking

Write in the time of day child usually wakes in the morning: _____

	Usually (5-7)	Sometimes (2-4)	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
Adult 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

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Daytime Sleepiness

	Usually (5-7)	Sometimes (2-4)	Rarely (0-1)	Problem?
Child naps during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes No N/A
Child suddenly falls asleep in the middle of active behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes No N/A
Child seems tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes No N/A

During the past week, your child has appeared very sleepy or fallen asleep during the following (check all that apply):

	Very Sleepy	Falls Asleep
Play alone	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>
Riding in car	<input type="checkbox"/>	<input type="checkbox"/>
Eating meals	<input type="checkbox"/>	<input type="checkbox"/>