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

Washington DC Location:
Pulmonary & Sleep Medicine Clinic, Suite 1030
111 Michigan Ave NW
Washington DC, 20010

Rockville Location:
Pulmonary Medicine Department, 4th Floor
9850 Key West Avenue
Rockville, Maryland 20850

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

↑: Waking Up/ Night Waking

: Awake (non-shaded block)

: Asleep (shaded block)

F: Breast/Bottle Feeding

⇓ **Midnight** ⇓ **Noon**

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**		↑					↓	N	A	P	↑					↓		

CHILDREN'S NATIONAL MEDICAL CENTER
PEDIATRIC SLEEP CLINIC QUESTIONNAIRE
BACKGROUND INFORMATION

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: _____

Referred 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*:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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).

Family Member	Type of Sleep Problem
_____	_____
_____	_____
_____	_____
_____	_____

Please list any family members with a history of mental health problems (such as depression, ADHD, anxiety, alcoholism/ substance abuse).

Family Member	Type of Mental Health Problem

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)

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

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, INAHLERS, NEBULIZED MEDICATIONS,

Type _____ Reason for medication: _____

Type _____ Reason for medication: _____

Type _____ Reason for medication: _____

Child Sleep Questionnaire

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 <u>School Nights</u>:

<u>School Nights are considered:</u>

Sunday	Monday	Tuesday	Wednesday	Thursday
				

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: **Please circle one number**

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 <u>Weekend/Vacation Nights</u>:

<u>Weekend Nights are considered:</u>

Friday	Saturday
	

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.

	Never	Not during the past month	Less than once a week	1 or 2 times a week	3 or 4 times a week	5 or more times a week
55 How often is there a ***regular bedtime routine*** in your home?	☐	☐	☐	☐	☐	☐
56. How often does your child ***share a bedroom*** with another family member?	☐	☐	☐	☐	☐	☐
57. How often does your child ***sleep in a caretaker's bed***?	☐	☐	☐	☐	☐	☐
58. How often does your child ***resist going to bed***?	☐	☐	☐	☐	☐	☐
59. How often is bedtime and the hour leading up to it ***a stressful time***?	☐	☐	☐	☐	☐	☐
60. After bedtime, how often does your ***child call you back*** to the bedroom more than 2 times?	☐	☐	☐	☐	☐	☐
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						
62. How often do you observe your child while s/he sleeps?	☐	☐	☐	☐	☐	☐
63. How often does your child snore?	☐	☐	☐	☐	☐	☐
63a. If your child snores, it can be heard…. Please check one: □ only in her/his bedroom □ one room away □ two or more rooms away on the same floor □ throughout the entire house						
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						

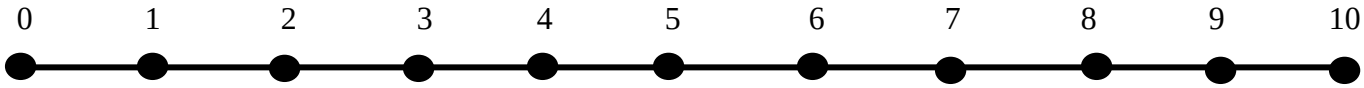
	Never	Not during the past month	Less than once a week	1 or 2 times a week	3 or 4 times a week	5 or more times a week
64a. If yes, how often do these breathing problems occur?	☐	☐	☐	☐	☐	☐
65. How often does your child grind her/his teeth while sleeping?	☐	☐	☐	☐	☐	☐
66. How often is your child a restless sleeper?	☐	☐	☐	☐	☐	☐
67. How often does your child wet her/his bed at night?	☐	☐	☐	☐	☐	☐
67a. If your child wets the bed has s/he ever been completely dry for more than one week? ☐ Yes ☐ No						
68. How often does your child report having nightmares or frightening dreams?	☐	☐	☐	☐	☐	☐
69. How often does your child wake up during the night screaming, agitated or confused?	☐	☐	☐	☐	☐	☐
69a. If yes, does s/he calm down after being comforted? Please check <u>one</u>: ☐ Yes ☐ No Please provide any specific details: _____						
69b. If yes, does s/he remember waking up the next morning? ☐ Yes ☐ No						
70. How often does your child sleep walk?	☐	☐	☐	☐	☐	☐
70a. While sleepwalking has s/he ever: Please check <u>all</u> that apply: ☐ been at risk of injury ☐ been injured ☐ attempted to leave the bedroom ☐ attempted to leave the home						
71. Does your child have repetitive movements during sleep? For example (please check <u>all</u> that apply): ☐ leg jerks ☐ head banging ☐ lip smacking ☐ other (please specify): _____						
72. How often does your child fall asleep suddenly at unexpected times?	☐	☐	☐	☐	☐	☐
73. How often does your child report having very real dreams that there is a person or animal in her/his room?	☐	☐	☐	☐	☐	☐
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? ☐ less than 1/month ☐ 1-3 times/ month ☐ 1-2 times/ month ☐ Almost always						

Please rate your child's chances of falling asleep or dozing in each of the situations listed below. Think about a typical day:

Please check one:

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

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



Not Concerned **Moderately Concerned** **Extremely Concerned**

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

_____

_____

_____

THANK YOU!