National Jewish Health™
Science Transforming Life®

Sleep Center
1400 Jackson Street
Denver, Colorado 80206
303.270.2708
www.nationaljewish.org

Dear Parent or Guardian of

Welcome to the National Jewish Health Pediatric Sleep Clinic. This letter is to confirm your appointment on _____/_____/_____ at _____p.m. Please report to the Sleep Clinic in the basement of the May Building.

If you are running late or cannot keep your scheduled appointment, please call 303-270-2708 option 2, as it may be necessary to reschedule your appointment.

In order to expedite your appointment **please review and complete the attached questionnaire, including a sleep diary that should be completed for 1-2 weeks prior to your child's visit,** and bring it with you at the time of the visit. **This form is an important part of your initial visit**.

PLEASE NOTE:

1. National Jewish Health treats many people with respiratory disorders whose symptoms can be triggered by certain scents. **Please DO NOT wear any of the following**:
   - Perfumes
   - Scented lotions
   - Colognes
   - Aftershave

2. **Parent or Legal Guardian MUST accompany all patients under the age of 18.** If this is hardship (Mom and/or Dad cannot get off from work) for follow up appointments, please discuss this with the physician at the time of your first appointment and we will try and make a plan with you.

If you have any questions prior to your visit, please call 303-270-2708.

PLEASE CHECK IN FOR YOUR PEDIATRIC SLEEP APPOINTMENT IN THE SLEEP CLINIC, WHICH IS IN THE BASEMENT OF THE MAY BUILDING

SLEEP LOG INSTRUCTIONS

- Please keep a daily log of your child's sleep for every day (for up to two weeks) before their clinic visit.

- To show the time your child gets in bed, please mark that time with a down arrow (↓).

- Please shade in the time that your child is asleep.

- To show the time your child wakes up and/or gets out of bed (either during the night or in the morning), please mark that time with an up arrow (↑).

On the bottom of your sleep log is an example line. The markings show that this child went to bed at 9:30pm (↓), was asleep from 10:00pm to 2:00am (↑), was awake and/or out of bed from 2:00-3:00am, and was asleep again from 3:00am to 7:00am, and got out of bed at 7:30am. This child also took a nap from 1:00pm to 3:00pm.

Please note, each day of the sleep diary starts at 6pm, so if you are recording for Tuesday, you will start with Tuesday at 6pm and record through Wednesday 6pm on the first line. The second line will be Wednesday 6pm through Thursday 6pm, and so on.

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Sleep Diary

Name: Dob: / /

Date Started: / / Date Ended: / /

List Medications:

Day	6p	7	8	9	10	11	12	Midnight 1	2	3	4	5	6	7	8	9	10	11	12	Noon 1	2	3	4	5	Comments

Day	6p	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	Comments
Example				↓	■	■	■	■	↑	↓	■	■	■	■	↑					↓	■	■	↑			

Key: down arrow = in bed up arrow = out of bed shaded = asleep (can have unshaded space between arrows, in bed not asleep)

NJ4Kids Sleep Clinic, National Jewish Health, Denver, CO Fax: (303)270-2109 attn: Lisa Meltzer

Sleep Evaluation Questionnaire

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

CHILD'S INFORMATION			
Child's name:		Child's gender: ☐ Male ☐ Female	
Child's birth date:		Child's age:	
Child's racial/ethnic background:	☐ White/Caucasian ☐ Native-American ☐ Other	☐ Black/African-American ☐ Hispanic-Latino	☐ Asian-American ☐ Multi-racial
Child's height:		Child's weight:	

REASON FOR VISIT
What are your major concerns about your child's sleep?
What things have you tried to help your child's problem?

SLEEP HISTORY

WEEKDAY SLEEP SCHEDULE

Write in the amount of time child sleeps during a 24-hour period on weekdays (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on weekday nights : _____:_____

The child's usual waketime on weekday mornings: _____:_____

WEEKEND/VACATION SLEEP SCHEDULE

Write in the amount of time child sleeps during a 24-hour period during weekends and vacations (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on weekend/vacation nights : _____:_____

The child's usual waketime on weekend/vacation mornings: _____:_____

NAP SCHEDULE

Number of days each week child takes a nap: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

If child naps, write in usual nap time(S): Nap 1: _____ : _____ ☐ a.m. ☐ p.m. to _____ : _____ ☐ a.m. ☐ p.m.

Nap 2: _____ : _____ ☐ a.m. ☐ p.m. to _____ : _____ ☐ a.m. ☐ p.m.

GENERAL SLEEP

Does the child have a regular bedtime routine? ☐ yes ☐ no

Does the child have his/her own bedroom? ☐ yes ☐ no

Does the child have his/her own bed? ☐ yes ☐ no

Is a parent present when your child falls asleep? ☐ yes ☐ no

Child usually falls asleep in…	Child sleeps most of the night in…	Child usually wakes in the morning in…
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ own room in own bed (alone)
☐ parents' room in own bed	☐ parents' room in own bed	☐ parents' room in own bed
☐ parents' room in parents' bed	☐ parents' room in parents' bed	☐ parents' room in parents' bed
☐ sibling's room in own bed	☐ sibling's room in own bed	☐ sibling's room in own bed
☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed

Child is usually put to bed by: ☐ Mother ☐ Father ☐ Both Parents ☐ Self ☐ Others

Write in the amount of time the child spends in his/her bedroom before going to sleep: _____ minutes

Child resists going to bed?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child has difficulty falling asleep?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child awakens during the night?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
After nighttime awakening, child has difficulty falling back to sleep?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child is difficult to awaken in the morning?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no
Child is a poor sleeper?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes	☐ no

CURRENT SLEEP SYMPTOMS							
							(f) do not know
						(e) always (6 to 7 nights/days a week)	
					(d) often (3 to 5 nights/days a week)		
				(c) sometimes (1 to 2 nights/days a week)			
			(b) not often (less than 1 night/day a week)				
		(a) never (does not happen)					
1.	Difficulty breathing when asleep	a	b	c	d	e	f
2.	Stops breathing during sleep	a	b	c	d	e	f
3.	Snores	a	b	c	d	e	f
4.	Restless sleep	a	b	c	d	e	f
5.	Sweating when sleeping	a	b	c	d	e	f
6.	Daytime sleepiness	a	b	c	d	e	f
7.	Poor appetite	a	b	c	d	e	f
8.	Nightmares	a	b	c	d	e	f
9.	Sleepwalking	a	b	c	d	e	f
10.	Sleeptalking	a	b	c	d	e	f
11.	Screaming in his/her sleep	a	b	c	d	e	f
12.	Kicks legs in sleep	a	b	c	d	e	f
13.	Wakes up at night	a	b	c	d	e	f
14.	Gets out of bed at night	a	b	c	d	e	f
15.	Trouble staying in his/her bed	a	b	c	d	e	f
16.	Resists going to bed at bedtime	a	b	c	d	e	f
17.	Grinds his/her teeth	a	b	c	d	e	f
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19.	Wets bed	a	b	c	d	e	f

CURRENT DAYTIME SYMPTOMS							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 day a week)				
		(a) never (does not happen)					
1.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f

MEDICAL AND PSYCHIATRIC HISTORY				
PREGNANCY/ DELIVERY				
Pregnancy	☐ Normal	☐ Difficult		
Delivery	☐ Term	☐ Pre-term	☐ Post-term	
Child's birthweight:				
Only child?	☐ Yes	☐ No	If no, circle birth order: 1st 2nd 3rd 4th 5th 6th 7th	
PAST MEDICAL HISTORY				
Frequent nasal congestion		☐ Yes	Age of diagnosis:	
Trouble breathing through his/her nose		☐ Yes	Age of diagnosis:	
Sinus problems		☐ Yes	Age of diagnosis:	
Chronic bronchitis or cough		☐ Yes	Age of diagnosis:	
Allergies		☐ Yes	Age of diagnosis:	Allergic to what:
Asthma		☐ Yes	Age of diagnosis:	
Frequent colds or flus		☐ Yes	Age of diagnosis:	
Frequent ear infections		☐ Yes	Age of diagnosis:	
Frequent strep throat infections		☐ Yes	Age of diagnosis:	
Difficulty swallowing		☐ Yes	Age of diagnosis:	
Acid reflux (gastroesophageal reflux)		☐ Yes	Age of diagnosis:	
Poor or delayed growth		☐ Yes	Age of diagnosis:	
Excessive weight		☐ Yes	Age of diagnosis:	
Hearing problems		☐ Yes	Age of diagnosis:	
Speech problems		☐ Yes	Age of diagnosis:	
Vision problems		☐ Yes	Age of diagnosis:	
Seizures/Epilepsy		☐ Yes	Age of diagnosis:	
Morning headaches		☐ Yes	Age of diagnosis:	
Cerebral palsy		☐ Yes	Age of diagnosis:	
Heart disease		☐ Yes	Age of diagnosis:	
High blood pressure		☐ Yes	Age of diagnosis:	
Sickle cell disease		☐ Yes	Age of diagnosis:	
Genetic disease		☐ Yes	Age of diagnosis:	
Chromosome problem (e.g., Down's)		☐ Yes	Age of diagnosis:	
Skeleton problem (e.g., dwarfism)		☐ Yes	Age of diagnosis:	
Cranofacial disorder (e.g., Pierre-Robin)		☐ Yes	Age of diagnosis:	
Thyroid problems		☐ Yes	Age of diagnosis:	
Eczema (itchy skin)		☐ Yes	Age of diagnosis:	
Pain		☐ Yes	Age of diagnosis:	

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY		
Autism	☐ Yes	Age of diagnosis:
Developmental delay	☐ Yes	Age of diagnosis:
Hyperactivity/ADHD	☐ Yes	Age of diagnosis:
Anxiety/Panic Attacks	☐ Yes	Age of diagnosis:
Obsessive Compulsive Disorder	☐ Yes	Age of diagnosis:
Depression	☐ Yes	Age of diagnosis:
Suicide	☐ Yes	Age of diagnosis:
Learning disability	☐ Yes	Age of diagnosis:
Drug use/abuse	☐ Yes	Age of diagnosis:
Behavioral disorder	☐ Yes	Age of diagnosis:
Psychiatric Admission	☐ Yes	Age of diagnosis:
Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.		

CURRENT MEDICAL HISTORY		
Please list any medications your child currently takes:		
Medicine	Dose	How often?
1.		
2.		
3.		
4.		

LONG-TERM MEDICAL PROBLEMS
If your child has long-term medical problems, please list them.

SURGERIES/HOSPITALIZATIONS			
Has your child ever had his/her tonsils removed?	☐ Yes	Age:	Reason for surgery:
Has your child ever had his/her adenoids removed?	☐ Yes	Age:	Reason for surgery:
Has your child ever had ear tubes?	☐ Yes	Age:	
Please list any additional hospitalizations or surgeries:			

HEALTH HABITS			
Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)	☐ No	☐ Yes	Amount per day:

SCHOOL PERFORMANCE					
CURRENT SCHOOL PERFORMANCE (if school-aged)					
Your child's grade:					
Has your child ever repeated a grade?	☐ No	☐ Yes			
Is your child enrolled in any special education class?	☐ No	☐ Yes			
How many school days has your child missed so far this year?					
How many school days did your child miss last year?					
How many school days was your child late so far this year?					
How many school days was your child late last year?					
Child's grades this year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing
Child's grades last year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing

FAMILY'S INFORMATION		
MOTHER		**FATHER**
Age:		Age:
Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried		Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried
Education:		Education:
Work: ☐ Home full-time ☐ Part-time ☐ Full-time		Work: ☐ Home full-time ☐ Part-time ☐ Full-time
Occupation:		Occupation:

PERSONS LIVING IN HOME		
Name:	Relationship	Age

FAMILY SLEEP HISTORY				
Does anyone in the family have a sleep disorder? ☐ Yes ☐ No				
If yes, mark the disorder(s):				
Insomnia	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent

REFERRAL	
Who asked that your child be seen by a sleep specialist?	
_____	Pediatrician/Family physician
_____	Child's parent or guardian
_____	Surgical specialist (e.g., ENT)
_____	Pediatric specialist (e.g., allergist, neurologist, pulmonolgist)
_____	Mental health specialist (e.g. psychiatrist, psychologist, social worker)
_____	School teacher, nurse, counselor
_____	Child himself/herself
_____	Other:

IF YOUR CHILD IS 8 YEARS OR OLDER, PLEASE HAVE THEM FILL OUT THE NEXT THREE PAGES

Please respond to each question or statement by marking one box per row.
There are no right or wrong answers.

In the past 7 days…	Never	Almost never	Sometimes	Almost always	Always
I had difficulty falling asleep					
I slept through the night					
I had a problem with my sleep					
I had trouble sleeping					

In the past 7 days…	Never	Almost never	Sometimes	Almost always	Always
I was sleepy during the daytime					
I had a hard time concentrating because I was sleepy					
I had a hard time getting things done because I was sleepy					
I had problems during the day because of poor sleep					

In the past 7 days…	Never	Almost never	Sometimes	Almost always	Always
I followed a bedtime routine before falling asleep					
I watched TV/videos just before falling asleep					
I played video/computer games just before falling asleep					
I tried to fall asleep at about the same time every night					
I needed someone with me to fall asleep					
I used a phone, computer, or electronic device just before falling asleep					
I woke up at about the same time every morning					

THINKING ABOUT MY SLEEP

INSTRUCTIONS

Sentences about some people's beliefs and attitudes about sleep are listed below. Please circle the number that shows how much you agree or disagree with each sentence. There are no right or wrong answers.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1) I must always have at least 9 hours of sleep to function well or do well during the day.	1	2	3	4	5
2) When I don't get the sleep I need on a particular night, I must catch up the next day by napping or by sleeping longer the next night.	1	2	3	4	5
3) I am really worried that difficulty falling or staying asleep over a long period of time might affect my physical appearance.	1	2	3	4	5
4) When I have trouble getting to sleep, I should stay in bed and try harder.	1	2	3	4	5
5) When I have trouble getting to sleep it makes me worry that I may stop being able to sleep.	1	2	3	4	5
6) When I don't get the sleep I need I know that it will really affect the things that I do the next day.	1	2	3	4	5
7) When I feel annoyed, sad, or worried during the day, it is always because I didn't get the sleep I needed the night before.	1	2	3	4	5
8) When I don't get the sleep I need on one night I know it will disturb the way I sleep for the whole week.	1	2	3	4	5
9) When I feel tired, have no energy, or just seem to do badly during the day it is always because I didn't get the sleep I needed the night before.	1	2	3	4	5
10) When I have lots of thoughts at night I usually feel that I cannot control all these thoughts that I am having.	1	2	3	4	5

Please think about if you were allowed to pick your own sleep schedule so that you feel the most awake and can do your best. There are no right or wrong answers.

You should answer the questions based on your body's "feeling best" times.

1. **Imagine: School is cancelled! You can get up whenever you want to. When would you get out of bed? Between:**
   - ☐ 5:00 and 6:29 am
   - ☐ 6:30 and 7:45 am
   - ☐ 7:45 and 9:45 am
   - ☐ 9:45 and 11:00 am
   - ☐ 11:00 am and 12:00 pm

2. **Is it easy for you to get up in the morning?**
   - ☐ No way!
   - ☐ Sort of
   - ☐ Pretty easy
   - ☐ Really easy

3. **Gym class is set for 7:00 in the morning. How do you think you'll do?**
   - ☐ My best!
   - ☐ Okay
   - ☐ Worse than usual
   - ☐ Awful

4. **The bad news: You have to take a two-hour test. The good news: You can take it when you think you'll do your best. What time is that?**
   - ☐ 8:00 to 10:00 a.m.
   - ☐ 11:00 a.m. to 1:00 p.m.
   - ☐ 3:00 to 5:00 p.m.
   - ☐ 7:00 to 9:00 p.m.

5. **When do you have the most energy to do your favorite things?**
   - ☐ Morning! I am tired in the evening
   - ☐ Morning more than evening
   - ☐ Evening more than morning
   - ☐ Evening! I am tired in the morning

6. **Your parents have decided to let you set your own bed time. What time would you pick? Between…**
   - ☐ 8:00 and 9:00 pm
   - ☐ 9:00 and 10:15 pm
   - ☐ 10:15 pm and 12:30 am
   - ☐ 12:30 and 1:45 am
   - ☐ 1:45 and 3:00 am

7. **How alert are you in the first half hour you're up?**
   - ☐ Out of it
   - ☐ A little dazed
   - ☐ Okay
   - ☐ Ready to take on the world

8. **When does your body start to tell you it's time for bed (even if you ignore it)? Between…**
   - ☐ 8:00 and 9:00 pm
   - ☐ 9:00 and 10:15 pm
   - ☐ 10:15 pm and 12:30 am
   - ☐ 12:30 and 1:45 am
   - ☐ 1:45 and 3:00 am

9. **Say you had to get up at 6:00 am every morning: What would it be like for you?**
   - ☐ Awful!
   - ☐ Not so great
   - ☐ Okay (if I have to)
   - ☐ Fine, no problem!

10. **When you wake up in the morning how long does it take for you to "get going"?**
    - ☐ 0 to 10 minutes
    - ☐ 11 to 20 minutes
    - ☐ 21 to 40 minutes
    - ☐ More than 40 minutes