

Sleep Medicine Services of Western Massachusetts, LLC  
**Sleep Inventory – Pediatrics**

Child's name \_\_\_\_\_

Parent/caregiver \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Child typically goes to bed around \_\_\_\_\_pm and wakes for the day at \_\_\_\_\_am and generally has \_\_\_\_\_ naps during the day at \_\_\_\_\_am/pm.

Regular bedtime routine involves ☐ TV ☐ reading ☐ bath ☐ other \_\_\_\_\_ ☐ no routine

Child is usually put to bed by ☐ mother ☐ father ☐ other caregiver ☐ self

Child typically sleeps in ☐ their own bed ☐ parents' bed ☐ sibling's bed

Child typically sleeps in ☐ their own room ☐ parents' room ☐ shared room with sibling

Is a parent/caregiver present when the child falls asleep? ☐ yes ☐ no

How much time does the child generally spend in the bedroom before going to sleep? \_\_\_\_\_

When child wakes during the night, returns to ☐ own bed (alone) ☐ own bed (with parent) ☐ parents' bed ☐ sibling's bed ☐ other \_\_\_\_\_

On weekends, this routine is ☐ the same ☐ different – with bedtime at \_\_\_\_\_pm and waking at \_\_\_\_\_am

Does your child resist going to bed? ☐ yes ☐ no

Do you think this is a problem? ☐ yes ☐ no

Does your child have difficulty falling asleep? ☐ yes ☐ no

Do you think this is a problem? ☐ yes ☐ no

Does your child awaken during the night? ☐ yes ☐ no

Do you think this is a problem? ☐ yes ☐ no

After a nighttime awakening, does your child have difficulty falling back asleep? ☐ yes ☐ no

Do you think this is a problem? ☐ yes ☐ no

Is your child difficult to awaken in the morning? ☐ yes ☐ no

Do you think this is a problem? ☐ yes ☐ no

Please check any of the following that have been noticed:

- |   |   |
|---|---|
| <input type="checkbox"/> frequent snoring   | <input type="checkbox"/> labored breathing during sleep           |
| <input type="checkbox"/> gasps/snorting noises or observed episodes of apnea (stopping breathing) | <input type="checkbox"/> blue coloration of the skin              |
| <input type="checkbox"/> bedwetting   | <input type="checkbox"/> restless sleep/kicking legs during sleep |
| <input type="checkbox"/> morning headaches  | <input type="checkbox"/> sleep walking                            |
| <input type="checkbox"/> daytime sleepiness   | <input type="checkbox"/> sleep talking                            |
| <input type="checkbox"/> behavioral problems or concerns with possible ADD/ADHD                   | <input type="checkbox"/> teeth grinding                           |
| <input type="checkbox"/> screaming during sleep   | <input type="checkbox"/> uncomfortable feeling in legs            |
| <input type="checkbox"/> learning problems  | <input type="checkbox"/> feels weak or loses control of muscles   |
| <input type="checkbox"/> falling asleep in school   | <input type="checkbox"/> with strong emotions                     |
| <input type="checkbox"/> reports being unable to move when falling asleep or upon waking          |   |
| <input type="checkbox"/> sees frightening visual images before falling asleep or upon waking      |   |

Was the child born pre-term? ☐ yes ☐ no

Please list any medications:

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Allergies:

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Surgeries:

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Medical problems/conditions:

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Family history:

Mother: ☐ living ☐ deceased Medical problems

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Father: ☐ living ☐ deceased Medical problems

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Please check any symptoms that your child may have had recently:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> fever                  | <input type="checkbox"/> recent change in bowel habits      | <input type="checkbox"/> intolerance of hot or cold      |
| <input type="checkbox"/> temperatures           |   |  |
| <input type="checkbox"/> chills                 | <input type="checkbox"/> loss of bowel control              | <input type="checkbox"/> change in appetite              |
| <input type="checkbox"/> weight loss            | <input type="checkbox"/> black or bloody stool              | <input type="checkbox"/> difficulty controlling weight   |
| <input type="checkbox"/> fatigue                |   | <input type="checkbox"/> unusual thirst                  |
|   | <input type="checkbox"/> excessive urination                |  |
| <input type="checkbox"/> worsening of eyesight  | <input type="checkbox"/> loss of urinary control            | <input type="checkbox"/> unusual bruising                |
| <input type="checkbox"/> problems hearing       | <input type="checkbox"/> recurrent urination at night       | <input type="checkbox"/> excessive bleeding from cuts    |
| <input type="checkbox"/> persistent congestion  |   | <input type="checkbox"/> lumps in neck, armpits or groin |
| <input type="checkbox"/> persistent sore throat | <input type="checkbox"/> headache                           | <input type="checkbox"/> hives                           |
|   | <input type="checkbox"/> head injury                        | <input type="checkbox"/> swelling of the lips or tongue  |
| <input type="checkbox"/> chest pain             | <input type="checkbox"/> seizures or fainting               |  |
| <input type="checkbox"/> palpitations           | <input type="checkbox"/> speech disturbance                 |  |
| <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> forgetfulness or memory loss       |  |
| <input type="checkbox"/> persistent cough       | <input type="checkbox"/> pain in muscles or joints          |  |
|   | <input type="checkbox"/> tremor or involuntary movement     |  |
| <input type="checkbox"/> difficulty chewing     | <input type="checkbox"/> balance problems                   |  |
| <input type="checkbox"/> difficulty swallowing  | <input type="checkbox"/> unusual hair loss                  |  |
| <input type="checkbox"/> abdominal pain         |   |  |
| <input type="checkbox"/> diarrhea               | <input type="checkbox"/> feelings of anxiety or depression  |  |
| <input type="checkbox"/> constipation           | <input type="checkbox"/> hearing voices or seeing images    |  |
|   | <input type="checkbox"/> thoughts of harming self or others |  |