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:

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

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

Please list any medications:

_____
_____
_____
_____

Allergies:

_____

Surgeries:

_____

Medical problems/conditions:

_____
_____
_____

Family history:
Mother: □ living □ deceased Medical problems

_____

Father: □ living □ deceased Medical problems

_____

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

□ fever
□ chills
□ weight loss
□ fatigue

□ worsening of eyesight
□ problems hearing
□ persistent congestion
□ persistent sore throat

□ chest pain
□ palpitations
□ shortness of breath
□ persistent cough

□ difficulty chewing
□ difficulty swallowing
□ abdominal pain
□ diarrhea
□ constipation

□ recent change in bowel habits

□ loss of bowel control
□ black or bloody stool

□ excessive urination
□ loss of urinary control
□ recurrent urination at night

□ headache
□ head injury
□ seizures or fainting
□ speech disturbance
□ forgetfulness or memory loss
□ pain in muscles or joints
□ tremor or involuntary movement
□ balance problems
□ unusual hair loss

□ feelings of anxiety or depression
□ hearing voices or seeing images
□ thoughts of harming self or others

□ intolerance of hot or cold temperatures

□ change in appetite
□ difficulty controlling weight
□ unusual thirst

□ unusual bruising
□ excessive bleeding from cuts
□ lumps in neck, armpits or groin
□ hives
□ swelling of the lips or tongue