**SLEEP DISTURBANCES SCALE FOR CHILDREN**

***INSTRUCTIONS****: This questionnaire is used to provide a better understanding of the sleep-wake rhythm of your child and of any problems in his/her sleep behavior. Try to answer every question; in answering, consider each question as pertaining to the* ***past 6 months*** *of the child’s life. Please answer the questions by circling or striking the number 1 to 5.*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. How many hours of sleep does your child get on most nights?
 | 1*9-11 hours* | 2*8-9 hours* | 3*7-8 hours* | 4*5-7 hours* | 5*less than 5 hours* |
| 1. How long after going to bed does your child usually fall asleep?
 | 1*less than 15 min* | 2*15-30 min* | 3*30-45 min* | 4*45-60 min* | 5*more than 60 min* |

|  |
| --- |
| 5 **Always (daily)** |
| 4 **Often (3 or 5 times per week)** |  |
| 3 **Sometimes (once or twice per week)** |  |  |
| 2 **Occasionally (once or twice per month or less)** |  |  |  |
| 1 **Never** |  |  |  |  |
| 1. The child goes to bed reluctantly
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child has difficulty getting to sleep at night
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child feels anxious or afraid when falling asleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child startles or jerks parts of the body while falling asleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child shows repetitive actions such as rocking or head banging while falling asleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child experiences vivid dream-like scenes while falling asleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child sweats excessively while falling asleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child wakes up more than twice per night
 | 1 | 2 | 3 | 4 | 5 |
| 1. After waking up in the night, the child has difficulty falling asleep again
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child has frequent twitching or jerking of legs while asleep or often changes position during the night or kicks the covers off the bed.
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child has difficulty in breathing during the night
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child gasps for breath or is unable to breathe during sleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child snores
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child sweats excessively during the night
 | 1 | 2 | 3 | 4 | 5 |
| 1. You have observed the child sleepwalking
 | 1 | 2 | 3 | 4 | 5 |
| 1. You have observed the child talking in his/her sleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child grinds teeth during sleep
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child wakes from sleep screaming or confused so that you cannot seem to get through to him/her, but has no memory of these events the next morning
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child has nightmares which he/she doesn’t remember the next day
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child is unusually difficult to wake up in the morning
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child awakes in the morning feeling tired
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child feels unable to move when waking up in the morning
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child experiences daytime somnolence (sleepiness)
 | 1 | 2 | 3 | 4 | 5 |
| 1. The child falls asleep suddenly in inappropriate situations
2. My child has seizures while asleep

How many per night (on average) ☐N/A ☐1 ☐2 ☐3 – 5 ☐6 – 10 ☐>10 Please describe seizure type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. My child has difficulty falling asleep after a nocturnal seizure (if applicable)
2. My child takes medication to assist with sleep.

If yes, which medications (including dose) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1111 | 2222 | 3333 | 4444 | 5555 |

30. Has your child ever had a sleep problem in the past that is no longer an issue (Y/N)? \_\_\_\_\_\_