**Sleep questionnaire and diary**

**Bedtime routine for (child’s name):**

**Date of birth:**

**Completed by:**

**Date:**

♦ What time does your child go to bed during school days and weekends?

♦ What do you do in the ne/two hours leading up to bedtime?

♦ Does your child have trouble settling down at night?

* How long does it take your child to fall asleep after lights out?
* Does anybody need to be with the child while he/she is falling asleep?

♦ Are there any distractions in the room such as a television/computer/tablets etc.?

♦ Does your child share a bedroom? If so what is the age of the sibling?

♦ What time does your child wake up in the mornings during school days and weekends?

**Any difficulties during sleep:**

♦ Does your child wake during the night? If so, how many times?

♦ Does your child have any trouble settling back to sleep?

♦ Do they sleep walk, have nightmares or sleep terrors?

♦ Does your child snore, have you noticed pauses in breathing when asleep?

* Is your child restless in their sleep?

♦ Do they suffer with Asthma or any other medical problems? Such as adenoids/tonsils, eczema, constipation, bedwetting, gastro-oesophageal reflux, anaemia or seizures.

* Is your child currently on any medication and if so, what are the medications and the time they are taken?

**Daytime sleepiness and tiredness:**

* Do you think your child is getting enough sleep?

♦ Does your child have difficulty waking up in the morning?

♦ Does your child appear sleepy during the daytime? Any naps?

♦ Does your child tire easily during the daytime?

* What effect is your child’s sleep having on your child and family?

Thank you for completing this questionnaire

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **Activities before bedtime** |  |  |  |  |  |  |  |
| **List of last food/drink taken before bedtime and time taken** |  |  |  |  |  |  |  |
| **Bedtime and time slept** |  |  |  |  |  |  |  |
| **Times woke up got out of bed and how long for** |  |  |  |  |  |  |  |
| **Triggers for waking or getting up** |  |  |  |  |  |  |  |
| **Time woke in the morning and mood on waking** |  |  |  |  |  |  |  |
| **Sleepy during daytime, naps and any other problems** |  |  |  |  |  |  |  |
| **What strategies have you tried?** |  |  |  |  |  |  |  |
| **It is helpful to score 1-5****1=least helpful****5=most helpful** |  |  |  |  |  |  |  |

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