# Older Child/Adolescent Sleep Habits Questionnaire
## (Parent Report)

The following questions are about your child’s sleep habits and possible difficulties with sleep. The examiner will explain the form and will read the questions aloud if you wish. Please mark your answer to each question in the box or space provided. There are no right or wrong answers. Please ask if you do not understand a question. Thank you!

**For examiner:** R = REVERSE SCORING  
Read by examiner ________  
Read by parent ________

1. Who in your family sets the rules about when your child goes to bed?
   - [ ] Mom  
   - [ ] Dad  
   - [ ] Child  
   - [ ] Other: ____________________

2. Do you think your child has trouble sleeping?  
   - [ ] Yes, a lot  
   - [ ] Some  
   - [ ] No, not at all

3 a. Write in your son/daughter’s *bedtime* on a typical school/weekday night: __________________________

   b. Write in your son/daughter’s *bedtime* on a typical non-school/weekend night: __________________________

4 a. Write in your son/daughter’s *waketime* on a typical school/weekday night: __________________________

   b. Write in your son/daughter’s *waketime* on a typical non-school/weekend night: __________________________

5 a. On an average school night, does your child sleep:  
   - [ ] Too little  
   - [ ] The right amount  
   - [ ] Too much

   b. On an average non-school night, does your child sleep:  
   - [ ] Too little  
   - [ ] The right amount  
   - [ ] Too much

6. Share a bedroom
   - [ ] Usually (6-7 x/Week)  
   - [ ] Sometimes (3-5 x/Week)  
   - [ ] Rarely (1-2 x/Week)  
   - [ ] Never (0 x/Week)  
   - [ ] Don’t Know

7. Share a bed

8. Have a bedtime routine (R)

9. Go to bed at the same time every night (R)

10. Seem ready to go to bed at his/her usual bedtime (R)

11. Resist going to bed at bedtime

12. Take more than 30 minutes to fall asleep after “lights out”

13. Fall asleep within 5-10 minutes after “lights out”

14. Take any over-the-counter, prescription medications or natural products to help him/her fall asleep

   If yes, which one(s) __________________________

15. Need a parent/sibling present to fall asleep

16. Seem afraid of sleeping in the dark or of sleeping alone
17. Have a television set in the bedroom
18. Have a computer in the bedroom
19. Need TV or music on to fall asleep
20. Need to move his/her legs and/or complain of uncomfortable feelings in legs at bedtime

<table>
<thead>
<tr>
<th>SLEEP BEHAVIOR</th>
<th>Usually (6-7/Week)</th>
<th>Sometimes (3-5/Week)</th>
<th>Rarely (1-2 x/Week)</th>
<th>Never (0 x/Week)</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>Does your child:</td>
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<td>21. Sleep about the same amount each night (R)</td>
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<td>22. Talk during sleep</td>
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<td>23. Have nightmares</td>
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<td>24. Seem unusually restless, twitch/jerk, or move around a lot during sleep</td>
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<td>25. Sleepwalk during the night</td>
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<td>26. Report body pains at night</td>
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<td>If so, where is the pain?</td>
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<td>27. Grind his/her teeth during sleep</td>
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<td>28. Snore loudly</td>
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<td>29. Seem to stop breathing during sleep</td>
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<td>30. Sweat during sleep</td>
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<td>31. Report seeing or hearing things while falling asleep</td>
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<td>32. Report being unable to move while falling asleep</td>
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<td>33. Have trouble sleeping away from home (visiting relatives, vacation)</td>
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**WAKING DURING THE NIGHT**

Does your child:
34. Wake up during the night
   If so, how many times per night? __________
   How many minutes does a night waking usually last? __________

35. Return to sleep without help after waking (R)
36. Move to someone else’s bed during the night (parent, sibling, etc.)
37. Get up and wanders around at night when others are asleep
38. Lay awake at night worrying

**MORNING WAKING**

Does your child:
39. Wake up by him/herself on schooldays/weekday
**Research Version**

mornings (R)

40. Wake up by him/herself on non-schoolday/weekend mornings (R)

41. Wake up unusually early, before the normal wake-up time

42. Wake up irritable or in a negative mood

43. Need to be awakened by adults/siblings or alarm clock

44. Have a lot of difficulty getting out of bed in the morning

45. Take a long time to become alert in the morning

**SLEEP HABITS**

Does your child:

46. Drink caffeine products

47. Smoke or use tobacco

48. Exercise regularly (R)

49. Exercise just before bed

50. Have regular meal times (R)

**DAYTIME SLEEPINESS**

Does your child:

51. Complain of being tired during the day

52. Nap during the day

53. Seem to feel rested after a night’s sleep (R)

54. During the past week, how often has your son/daughter been very sleepy or fallen asleep during the following activities (check all that apply):

<table>
<thead>
<tr>
<th>Activity</th>
<th>(3) Often (6-7 x/week)</th>
<th>(2) Sometimes (3-5 x/week)</th>
<th>(1) Rarely (1 x/week)</th>
<th>(0) Never (0 x/Week)</th>
<th>Don’t Know</th>
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</thead>
<tbody>
<tr>
<td>a. Playing video games</td>
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<td>b. On the computer</td>
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<td>c. Doing homework or reading</td>
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<td>d. Sitting in class</td>
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<td>e. At his/her job</td>
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<td>f. Watching TV</td>
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<td>g. While eating</td>
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<td>h. During a conversation</td>
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