Sleep, Breathing & Habit Questionnaire — Children & Adolescents

Full Name:	Age:	Date:

Please indicate if your child experiences or has experienced any of these symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence 1 - Occurs Rarely 2 - Occurs 2 to 4 times per week 3 - Occurs 5 to 7 times per week

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bed wetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Seasonal allergies
18. _____ Ear infections of history of ear infections
19. _____ Short attention span
20. _____ Trouble focusing
21. _____ Difficulty listening/ often interrupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory Issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech issues*
28. _____ Avoidance behavior towards food or certain types of food

*Speech Questionnaire - to be filled out only if #27 was indicated above

Please check all that apply

_____ Is it difficult to understand your child's speech?

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Other have difficulty understanding speech?

_____ Gets frustrated when people can't understand speech?

_____ Speech sounds abnormal?

_____ Sometimes omits consonants?

_____ Uses M, N, NG instead of P, V, S, Z sounds?

_____ Liquids and/or solids get into nasal area when eating or drinking?

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