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Initial Pediatric Sleep Disorder Treatment Form

Childs Name: _____ Parent Name: _____

Date: ___/___/__ Childs Age (Years and/or Months) _____ Childs Sex: M / F

How likely is the following situation to happen for your child? This refers to your child's usual way of life in recent times. Even if your child has not done some of these things recently, try to work out how they would normally react in the situation. For example, a child on summer break from school or a child that no longer takes regular afternoon naps should still be scored. Use the scale below to choose the most appropriate number for each situation.

Pediatric Epworth Sleepiness Scale

0 = never; **1** = slight/infrequently; **2** = moderate/frequently; **3** = high/always

Situation*	Chance of Occurring
Snoring after falling asleep at night or during the day	_____
Tossing and turning in bed at night	_____
Having a short attention span in school or during the day	_____
Acting out or misbehaving in school or during the day	_____
Dozing off or falling asleep while watching television	_____
Dozing off or falling asleep while riding in a car	_____
Dozing off or falling asleep after eating lunch	_____
Dozing off or falling asleep while lying down for a nap or in school	_____
Total	_____

*The number for the eight situations are added together to give a global score between 0 and 24.

The Pediatric Fatigue Severity Scale

How fatigued is your child? This questionnaire refers to your child's usual way of life in recent times. The following nine situations are designed to rate the severity and impact of fatigue or physical tiredness on your child's life. Use the scale below to agree or disagree with the statements. Circle a number for each statement and add them up on the total line. Thank you for your help with this.

During the past week or so, I have found that:	Disagree ← → Agree
My child's motivation is lower when they are fatigued.	*1 2 3 4 5 6 7*
Exercise brings on my child's fatigue.	*1 2 3 4 5 6 7*
My child iseasily fatigued.	*1 2 3 4 5 6 7*
Fatigue interferes with my child's physical functioning.	*1 2 3 4 5 6 7*
Fatigue causes frequent problems for my child.	*1 2 3 4 5 6 7*
My child's fatigue prevents sustained physical functioning.	*1 2 3 4 5 6 7*
Fatigue interferes with carrying out certain responsibilities.	*1 2 3 4 5 6 7*
Fatigue is among my child's three most disabling symptoms.	*1 2 3 4 5 6 7*
Fatigue interferes with my child's family, or social life.	*1 2 3 4 5 6 7*
	Total=_____

*The number for the nine situations are added together to give a global score between 9 and 63.

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Insomnia Severity Index

Please answer each of the questions below by circling the number that best describes your child's sleep patterns. Please answer all questions.

1. Please rate the current (last 2 weeks) **SEVERITY** of your child's insomnia problem(s):

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

2. How **SATISFIED/DISSATISFIED** does your child seem to be with their current sleep pattern?

Very Satisfied				Very Dissatisfied
0	1	2	3	4

3. To what extent do you consider your child's sleep problem to **INTERFERE** with their daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?

Not at all Interfering	A little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

4. How **NOTICEABLE** to others do you think your child's sleeping problem is in terms of impairing the quality of their life?

Not at all Noticeable	A little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

5. How **WORRIED/DISTRESSED** does your child seem to be about their current sleep problem?

Not at all	A little	Somewhat	Much	Very Much
0	1	2	3	4

Total =_____

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