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?