Gila Lindsley, Ph.D.
SleepWell

7 White Pine Lane
Lexington, MA 02421-6321
781.862.7331

Please bring this with you to the first appointment.

SYMPTOM CHECKLIST FOR PEDIATRIC AND ADOLESCENT SLEEP-WAKE DISORDERS

Patient's Name: _____
Street: _____
City, State, Zip: _____

Date of Birth: __ __/ __ __ / __ __
Date of Visit: __ __/ __ __ / __ __
Medical Record:_____

Pediatrician:
Name: _____
Address: _____

_____

Reason for Visit:

Please describe your youngster's problem with nighttime sleep or daytime wakefulness. Provide whatever dates you can as to when the problem began, ways in which the problem may have changed over time, and events happening in the youngster's life which may have occurred at about the same time the problem began or during the evolution of the problem.

What are your own thoughts about what may be causing the problem; and what evaluations have you already had done for him or her? Under what circumstances is the problem less, under what circumstances more?

Telephone: (781) 862-7331
Fax: (781) 674-2526
Internet: DrLindsley@sleepwellservices.com

For each of the following symptoms which are relevant to your youngster, please indicate about when the symptom began (age at onset) or when it stopped (age at offset), and about how often the symptom occurs(ed).
When "you" is used, it refers to the youngster.

SYMPTOM	AGE AT ONSET OR OFFSET AS RELEVANT	FREQUENCY
Daytime Sleepiness or Fatigue		
Can't get to sleep at night		
Difficult to awaken in morning		
Sleeps in whenever possible		
Lack of Energy		
Inattentiveness in School		
Difficulty concentrating		
Doesn't seem to work up to known ability		
Low frustration threshold		
Angers easily		
Unexplained tearfulness		
Recent change in personality		

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SYMPTOM	AGE OF ONSET OR OFFSET AS RELEVANT	FREQUENCY
Resistance to , or difficulty, going to sleep at a reasonable time		
Resistance to staying alone in the bedroom		
Afraid of being in bedroom alone because of, for instance, monsters		
Complains thoughts won't turn off at bedtime		

CONSISTENT WITH RESPIRATORY DISTURBANCE DURING SLEEP:

SYMPTOM	AGE AT ONSET OR OFFSET AS RELEVANT	FREQUENCY
Snoring		
Wheezing or gasping during sleep		
Sleeps with neck hyper-extended		
Bedwetter beyond usual age of staying dry		
Obligatory mouth breather during sleep		
Unusually thirsty in the morning		

Evidence of airway obstruction because of inhalant allergies, nasal fracture, enlarged adenoids or tonsils, asthma		

CONSISTENT WITH DISORDER OF THE SLEEP-WAKE SCHEDULE (BIOLOGICAL RHYTHM DISTURBANCE)

SYMPTOM	AGE OF ONSET OR OFFSET AS RELEVANT	FREQUENCY
Sleep Walking		
Sleep Talking		
Sleep Terrors		
Does best with a very late to bed, very late to rise sleep schedule		
Not hungry for breakfast, starved late at night		

CONSISTENT WITH NARCOLEPSY

SYMPTOM	AGE OF ONSET	FREQUENCY
Unexplained daytime sleepiness		
Falls asleep in class, or at other times when not physically active		
Unexplained brief (up to 20 mins) naps which often contain dream material		

Feeling paralyzed when falling asleep and/or when waking up (especially from a dream)		
True hallucinations at onset of nighttime sleep or naps		
Sudden feelings of weakness in face, knees, whole body especially when laughing, angry, or with other feelings (partial cataplectic attack)		
Sudden loss of skeletomuscular tone which can lead to falling, especially when laughing, angry or with other feelings (full cataplectic attack)		
Unexplained withdrawal from friends		
Unexplained decrease in classroom performance		
Unexplained depression		
Family history of excessive daytime sleepiness		

Other comments about nighttime sleep and daytime function:

❖: HEALTH HABITS

To be completed by parents if for a younger child, and by patient if a teenager. Please note that especially for younger children, many of the questions in this set may be irrelevant.

1. About how much alcohol (e.g. number of cans of beer, ounces of scotch, etc.) do you drink, if any:

Alcohol Type (Beer, wine, hard liquor, etc.)	Unit Measurement (cans, glasses, shots, etc.)	Quantity per unit time (a 6-pack per week, bottle of wine every couple of weeks, etc.)

If you drank alcohol in the past, please indicate how much and when (*if none, please indicate none*): _____

Did you ever have, or do you currently have, an alcohol addiction?

If your answer is yes, are you involved with Alateen or another 12-step program?

2. How much coffee, tea, chocolate, caffeinated soft drinks, do you drink or eat daily? If none, please state none. Please note, diet soft drinks are not necessarily decaffeinated.

Caffeine Type (Caffeinated coffee, decaf coffee, tea, cocoa, etc.)	Unit Measurement (cups, pots, glasses, 12 oz cans, etc.)	Quantity per unit time (24 fluid ozs/day, two cups in the morning, 3 12 oz mugs/day, etc.)

If you have recently stopped using caffeine products, please indicate how much caffeine you had been using, approximate amount of time you were using caffeine, and when you stopped using the caffeine.

3. How many packs of cigarettes, if any, do you smoke daily, on the average? Also indicate how long you have been smoking. If none, please state none:

   Packs per day: _____

   Length of time smoking: _____

   If you smoked in the past, how many packs/day did you smoke then? (If none, please state none) _____

   If you did smoke, when did you stop. _____

   How long had you been smoking? _____

4. How much exercise do you get daily (if none, please state none):

   Type of exercise: _____

   How much exercise/day or week: _____

5. Do you have any weight, over-eating or under-eating problems? If none, please state none. If you do, please provide some detail.

6. What is your current height? _____ Weight? _____. If this is a change from in the past, please provide details:

7. Nutrition. Please describe the kinds of food you tend to eat for:

   breakfast: snacks:

lunch: liquids:
supper: supplements:

❖. STRESS

1. Please list the current stressors in your life:

2. How do you deal with stress, and how successful/unsuccessful your coping strategy is in actually alleviating the stress:

3. For those times when your coping strategy was not particularly successful, describe how you feel (e.g. headache, runaway thoughts, tension in head/neck/shoulders, poor sleep, irritable, etc.) when you DO feel stressed out:

4. When your standard coping strategies DON'T work, what are the second-line things you might do (e.g. talk to a friend, scream into a pillow, take a tranquilizer or other medication, write lists, etc.).

5. Please identify any other aspects of how you live your life or things you actually do which might have either positive or negative influence on your health:

C. PERSONAL AND FAMILY MEDICAL HISTORY

YOUR DOCTOR WILL PROVIDE US WITH AS MUCH MEDICAL INFORMATION AS HE OR SHE HAS IF YOU REQUEST HER OR HIM TO SEND THIS INFORMATION TO US. HOWEVER, SINCE SO MANY OF US EITHER SEE A DOCTOR INFREQUENTLY, SEE DIFFERENT DOCTORS FOR DIFFERENT PROBLEMS, ETC., IT IS POSSIBLE THAT NO ONE OF YOUR HEALTH CARE PROVIDERS HAS ALL RELEVANT INFORMATION. WE WOULD THEREFORE APPRECIATE YOUR ANSWERING THESE QUESTIONS YOURSELF.

1. Please check all illnesses, injuries, medical conditions which you have had and indicate approximate dates:

MEDICAL CONDITION	DATE OF ONSET/OFFSET	ASSOCIATED MEDICATIONS, TREATMENT
___ High Blood pressure		
___ Other Heart Problems (specify)		
___ Allergies (Please specify type)		
___ Nose Injury		
___ Frequent colds, sicknesses		
___ Asthma		
___ EBV virus (mono)		
___ Other lung problems (please specify)		
___ Thyroid problems		

MEDICAL CONDITION	DATE OF ONSET/OFFSET	ASSOCIATED MEDICATIONS, TREATMENT
___ Diabetes		
___ Hypoglycemia		
___ Arthritis		
___ Epilepsy		
___ Migraine headaches		
___ Tension headaches		
___ Digestive problems (specify)		
___ Other (specify)		

Please use this space to describe other medical concerns for the child or teenager:

2. Please list ALL medicines, other than those which you have already mentioned above which you *currently* take on a regular OR occasional basis. Include prescription and non-prescription (e.g. aspirin, Tylenol) drugs. If you are using birth control pills, please note this as well.

MEDICATION	PURPOSE FOR TAKING IT	DOSAGE	WHO PRE-SCRIBED?	DATE BEGAN

3. Now, please list all medications which you are *not* currently taking, but which you have taken on a regular basis in the past. Please indicate approximately how long you were using the drug, and about when you stopped taking it.

MEDICATION	HOW LONG USED	DATE STOPPED

If you have not included recreational drugs above, please also list any recreational drugs you have used, approximate dates when you used each drug, and approximate frequency of use of each drug.

4. Did you ever take any more of any of the above drugs or medications than was prescribed, or did anyone ever suggest that you were addicted to any of these? If so, please describe.

5. Please indicate any surgery you have had. Please provide approximate dates. Remember that a tonsillectomy is surgery:

SURGERY	APPROXIMATE DATES

6. If you have been hospitalized for any other reasons (i.e. other than for surgeries), please provide description/purpose of hospitalizations and approximate dates. Please include psychiatric hospitalizations, if relevant, in this section.

DESCRIPTION/ PURPOSE OF HOSPITALIZATION	APPROXIMATE DATES

7. Please list any special medical tests (like an electro-cardiogram for heart function, EEG because of a question of epilepsy or other nervous system problem, pulmonary function test because of a possible lung problem, etc.) you have had in the past ten years. Note also the reason for the test and the results if you have that information available.

TEST	APPROXIMATE DATE	PURPOSE OF TEST	RESULTS

PERTINENT FAMILY HISTORY

1. Please list biological family members (including grandparents, parents, siblings, children) who have difficulty either with snoring, with their sleep, or with staying awake during the day; or who have a sleep or wakefulness problem similar to yours:

Relationship of Family Member to You	Type of sleep/wake related problem

If you'd like, you can use this space to describe a family member's sleep problem in more detail:

2. Please list biological family members (including grandparents, parents, siblings, children) who have had an illness which required sustained treatment (e.g. heart disease, high blood pressure, diabetes); problems with alcohol or drug abuse; with chronic depression, anxiety, other psychiatric illness. Specify each condition and the relationship of the person to you.

Relationship of Family Member to You	Type of Medical/Alcohol/Psychiatric/ Etc. Problem

Thank you for taking the time to complete this long questionnaire. Some of the information requested may not be relevant to you (or your child), of course. Of greatest importance, ALL the information provided in your (or your child's) answers will be taken into consideration in reaching a diagnosis, and then developing a treatment plan.