For each of the following questions circle yes, no, or don’t know as best describes your child’s sleep.

**While sleeping, does your child …**
1. Snore more than half the time?  Yes  No  Don’t know
2. Always snore?  Yes  No  Don’t know
3. Snore loudly?  Yes  No  Don’t know
4. Have ‘heavy’ or loud breathing?  Yes  No  Don’t know
5. Have trouble breathing, or struggle to breathe?  Yes  No  Don’t know

**Have you ever …**
6. Seen your child stop breathing during the night?  Yes  No  Don’t know

**Does your child …**
7. Tend to breathe through the mouth during the day?  Yes  No  Don’t know
8. Have a dry mouth on waking in the morning?  Yes  No  Don’t know
9. Occasionally wet the bed?  Yes  No  Don’t know
10. Wake up feeling *un*refreshed in the morning?  Yes  No  Don’t know
11. Have a problem with sleepiness during the day?  Yes  No  Don’t know
12. Have a teacher or other supervisor comment that your child appears sleepy during the day?  Yes  No  Don’t know

**Other:**
13. Is it hard to wake up your child in the morning?  Yes  No  Don’t know
14. Does your child wake up with headaches in the morning?  Yes  No  Don’t know
15. Did your child stop growing at a normal rate at any time since birth?  Yes  No  Don’t know
16. Is your child overweight?  Yes  No  Don’t know

**This child often …**
17. Does not seem to listen when spoken to directly.  Yes  No  Don’t know
18. Has difficulty organizing tasks and activities.  Yes  No  Don’t know
19. Is easily distracted by extraneous stimuli.  Yes  No  Don’t know
20. Fidgets with hands or feet or squirms in seat.  Yes  No  Don’t know
21. Is ‘on the go’ or often acts as if ‘driven by a motor’.  Yes  No  Don’t know
22. Interrupts or intrudes on others (e.g., interrupts conversations or games).  Yes  No  Don’t know

For staff use only:  Number Yes: _____  Total (Yes + No) _____  Score (0.0-1.0) _____