Sleep Breathing Habit Questionnaire

Patient's Name: _____ Age: _____ Date: _____

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

0 - No Occurrence 1 - Occures 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 the 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 bedwetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Allergic symptoms
18. _____ Ear infections
19. _____ Short attention span
20. _____ Trouble Focusing
21. _____ Difficulty listening/often interupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory Issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech problems *
28. _____ Avoidance behavior towards food or or certain types of food

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

Please check all that apply to your child

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

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Others 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?

_____ Swallowing problems with liquids and solids getting into nose?