

Public Health Infant Sleep Questionnaire

To be used with children 4 months and up.

Many parents find that filling out this questionnaire gives them clues to areas of their child's sleep that might be causing concerns.

Child's full name _____ Your name and phone number _____

Child's birthdate _____ Age _____ Today's date _____

1. What is your goal for your child's sleep?

2. Does your child snore during sleep?

- | | |
|---|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> Only when he/she has a cold or allergies | <input type="checkbox"/> Almost always/always |

3. How would you describe your child's personality? (CHECK ALL THAT APPLY)

- Very active and wiggly
- Easily overstimulated by things in the world (for example sounds, lights)
- Very intense and cries or fusses a lot, she is hard to figure out
- Other _____

Please think about your child's sleep over the past 2 weeks in answering the following questions:

4. Where does your child sleep most of the time?: (CHECK ONE)

- | | |
|--|---|
| <input type="checkbox"/> In his/her own room | <input type="checkbox"/> In another room of the house |
| <input type="checkbox"/> In parents' room | <input type="checkbox"/> Other, please specify: |
| <input type="checkbox"/> In siblings or other's room | |

5. Which of the following does your child sleep in most of the time?

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Crib | <input type="checkbox"/> Bassinet | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Own bed (any size) | <input type="checkbox"/> Infant seat | |
| <input type="checkbox"/> Parents' bed | <input type="checkbox"/> Swing | |

6. In what position does your child sleep most of the night? (CHECK ONE)

- | | |
|---|--|
| <input type="checkbox"/> On his/her back | <input type="checkbox"/> On his/her side |
| <input type="checkbox"/> On his/her belly | <input type="checkbox"/> Other _____ |

7. Which of the following usually occurs on most nights for your child in the hour before bedtime? (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Bath | <input type="checkbox"/> Run around |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Play |
| <input type="checkbox"/> Read books/being read to | <input type="checkbox"/> Cuddle |
| <input type="checkbox"/> Rocked | <input type="checkbox"/> Say prayers |
| <input type="checkbox"/> Watch television | <input type="checkbox"/> Sing songs/listen to music |
| <input type="checkbox"/> Have dinner or a snack | <input type="checkbox"/> Play computer/phone games |
| <input type="checkbox"/> Have a bottle, drink, or nurse | <input type="checkbox"/> Other, please specify: |

8. In a typical 7-day week, how often does your child have the same bedtime routine?
- 1-2 nights per week 5-6 nights per week
 3-4 nights per week Every night
9. At night time how does your child fall asleep most of the time? (CHECK ALL THAT APPLY)
- While being bottle-fed In his/her own crib and with a parent in the room
 While being breast-fed/nursing In parent's bed and with a parent in the room
 While being rocked In another room of the house (e.g. living room)
 While being held Other, please specify:
 While watching television
 In swing or stroller
 In his/her own crib/alone in the room
 In parent's bed alone in the room
10. What time do you usually start your child's bedtime routine? _____
11. What time do you usually put your child to bed at night? (finished bedtime routine and in crib/bed) _____
12. How long does it typically take your child to fall asleep at night? (Most nights)
- Less than 5 min 31-60 min
 5-15 min More than 1h
 16-30 min
13. How often, if ever, does your child have a difficult time falling asleep at night?
- Every night 1-3 nights per months
 5-6 nights per week Less than once a month
 3-4 nights per week Never
 1-2 nights per week
14. How many times does your child typically wake during the night? _____ times per night
15. How often does your child wake during the night, if ever?
- Every night 1-3 nights per month
 5-6 nights per week Less than once a month
 3-4 nights per week Never
 1-2 nights per week
16. On the timeline below,
- **circle** "bedtime" and "up for the day".
 - **Indicate with an *** how often your child is awake during the night.



17. When your child wakes up during the night, what do you do? (CHECK ALL THAT APPLY)

- Pick up my child and hold/rock him/her until child asleep
- Pick up my child and put him/her back down while child is still awake
- Rub or pat my child but do not pick up or take out of crib/bed
- Feed my child and put him/her back into crib/bed drowsy but awake
- Feed my child until he/she is back to sleep
- Give my child a pacifier
- Change diaper
- Comfort my child verbally but don't pick up or take child out of crib/bed
- Bring my child into my bed
- Let my child cry and fall back to sleep by himself/herself
- Give my child a few minutes to see if he/she falls back to sleep
- Play with my child until child is ready to go back to sleep
- Watch television/a video with my child until he/she falls asleep
- Sing to child
- Other, please specify: _____

18. On a typical night, how much total time during the NIGHT is your child awake?

_____ hours _____ minutes

19. On a typical night, what is the longest stretch of time that your child is asleep without waking up?

_____ hours _____ minutes

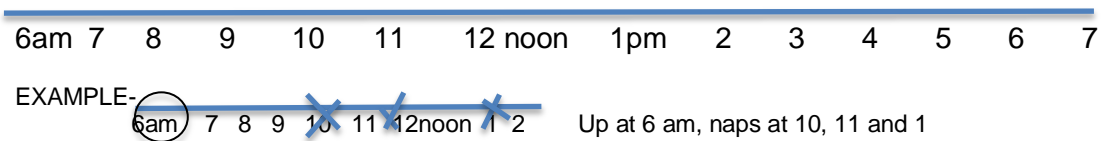
20. How much total time does your child spend sleeping during the NIGHT (7 in the evening to 6 in the morning) _____ hours _____ minutes

21. **At naptime** how does your child fall asleep most of the time? (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> While being bottle-fed | <input type="checkbox"/> In child's crib/bed and with a parent in the room |
| <input type="checkbox"/> While being breast-fed/nursing | <input type="checkbox"/> In parent's bed and with a parent in the room |
| <input type="checkbox"/> While being rocked | <input type="checkbox"/> In another room of the house (e.g. living room) |
| <input type="checkbox"/> While being held | <input type="checkbox"/> In the car |
| <input type="checkbox"/> While watching television | <input type="checkbox"/> Other, please specify: |
| <input type="checkbox"/> In swing or stroller | |
| <input type="checkbox"/> In child's crib/bed alone in the room | |
| <input type="checkbox"/> In parent's bed alone in the room | |

22. On the timeline below, **circle** the time that your child is "up for the day".

Indicate with a (x) when your child starts each nap during the day.



23. During the day, what is the longest stretch of time that your child typically sleeps?

_____hours _____minutes

24. How much total time does your child spend sleeping during the DAY (between 6 in the morning and 7 in the evening)

_____hours _____minutes

25. When your child is tired or upset, what **do you do** OR what does **your child do** to help calm?
(CHECK ALL THAT APPLY)

Child does this:

- Rub/touch own face or hair
- Rub/touch blanket/toy or other comfort object
- Suck thumb or fingers
- Rub/touch parents face or clothing
- Rub/touch parents face
- Breastfeed/drink from a bottle
- Other:_____

Parent does this:

- Say “shhh” loudly or sing to child
- Swaddle child
- Pat or rub child’s body
- Rock/Bounce/Sway or Jiggle child
- Breastfeed/drink from a bottle
- Offer pacifier or soother
- Other: _____

26. Is your child’s sleep causing stress for you or your family? (CHECK ONE)

- A very serious problem/ A lot of stress
- A small problem/ Some stress
- Not a problem at all/ No stress at all

27. How have you been coping with your child’s sleep?

28. What is the birth order of your child?_____

29. Other information you would like us to know about your child or your situation?