

# SLEEP SELF REPORT (Child's Form)

Coding

**R = REVERSE SCORING**

**HIGHER SCORE INDICATES MORE PROBLEMATIC SLEEP**

These questions are about your sleep. The researcher will explain the form and read you the questions in class. Please mark your answer to each question in the box. There are no right or wrong answers. Please ask if you do not understand a question. Thank you!

1. Who in your family sets the rules about when you go to bed?  
 Mom     Dad     You     Other: \_\_\_\_\_
2. Do you think you have trouble sleeping?     Yes                       No
3. Do you like to go to sleep?                       Yes                       No

<b><u>BEDTIME</u></b>	<b>(3) Usually (5-7)/ week</b>	<b>(2) Sometimes (2-4)/ week</b>	<b>(1) Rarely (0-1)/ week or never</b>
4. Do you go to bed at the same time every night on school nights? <b>(R)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you fall asleep in the same bed every night? <b>(R)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you fall asleep alone? <b>(R)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you fall asleep in parents', brothers', or sisters' bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you fall asleep in about 20 minutes? <b>(R)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you fight with your parents about going to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is it hard for you to go to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you ready for bed at your usual bedtime? <b>(R)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a special thing (doll, blanket, etc.) you bring to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you afraid of the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you afraid of sleeping alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you stay up late when your parents think you are asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>SLEEP BEHAVIOR</u></b>			
16. Do you think you sleep too little?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you think you sleep too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you wake up at night when your parents think you're asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have trouble falling back to sleep if you wake up during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Does pain wake you up at night? Where is that pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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22. Do you sometimes go to someone's bed during the night? If yes,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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who? \_\_\_\_\_

<b>(3)</b> <b>Usually</b> <b>(5-7)/</b> <b>week</b>	<b>(2)</b> <b>Sometimes</b> <b>(2-4)/</b> <b>week</b>	<b>(1)</b> <b>Rarely</b> <b>(0-1)/</b> <b>week or never</b>
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**DAYTIME SLEEPINESS**

- 23. Do you have trouble waking up in the morning?
- 24. Do you feel sleepy during the day?
- 25. Do you take naps during the day?
- 26. Do you feel rested after a night's sleep? **(R)**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>