Frontier Health and Wellness

Sleep Disturbance

Child Form

Name: _____ **Age: ____** **Sex: ❑ Male ❑ Female** **Date:_____**

Instructions to the child: The questions below ask about how often you have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

						Clinician Use
In the past SEVEN (7) DAYS....	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**	**Item Score**
My sleep was restless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
I was satisfied with my sleep.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
My sleep was refreshing.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
I had difficulty falling asleep.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
In the past SEVEN (7) DAYS....	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	
I had trouble staying asleep.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
I had trouble sleeping.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
I got enough sleep.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
In the past SEVEN (7) DAYS....	**Very Poor**	**Poor**	**Fair**	**Good**	**Very good**	
My sleep quality was...	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
					Total/Partial Raw Score:	
					Prorated Total Raw Score:	
					T-Score:	N/A

[1]This measure has not been validated in children.