



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.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I was satisfied with my sleep.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
My sleep was refreshing.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
I had difficulty falling asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
In the past SEVEN (7) DAYS....	Never	Rarely	Sometimes	Often	Always	
I had trouble staying asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I had trouble sleeping.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I got enough sleep.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
In the past SEVEN (7) DAYS....	Very Poor	Poor	Fair	Good	Very good	
My sleep quality was...	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
Total/Partial Raw Score:						
Prorated Total Raw Score:						
T-Score:						N/A

¹This measure has not been validated in children.

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