



## Sleep Disturbance Parent/Guardian of Child Age 6-17

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

What is your relationship with the child receiving care? \_\_\_\_\_

**Instructions to parent/guardian:** The questions below ask about how often your child receiving care has 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
Please respond to each item by choosing one option per question.						Item Score
<b>In the past SEVEN (7) DAYS....</b>	<b>Not at all</b>	<b>A little bit</b>	<b>Somewhat</b>	<b>Quite a bit</b>	<b>Very much</b>	
His/her sleep was restless.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
He/she was satisfied with his/her sleep.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
His/her sleep was refreshing.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
He/she had difficulty falling asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
<b>In the past SEVEN (7) DAYS....</b>	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>	
He/she had trouble staying asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
He/she had trouble sleeping.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
He/she got enough sleep.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
<b>In the past SEVEN (7) DAYS...</b>	<b>Very Poor</b>	<b>Poor</b>	<b>Fair</b>	<b>Good</b>	<b>Very good</b>	
His/her sleep quality was...	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	
<b>Total/Partial Raw Score:</b>						
<b>Prorated Total Raw Score:</b>						
<b>T-Score:</b>						N/A <sup>1</sup>

<sup>1</sup>This measure has not been validated in children.

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