Mid-Michigan Sleep Center

CHILD HEALTH QUESTIONNAIRE

(to be completed by the child, with parent help if needed)

Name: **Date:**

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? (use "√" to indicate your answer)	Not at all	Several days	More than ha. the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, sad, or hopeless. Or feeling irritable and cranky.				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself -- or that you cannot do anything right or have let yourself or your family down				
7. Trouble concentrating on things, such as homework or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
		add colums:	+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).		**Total:**		
10. Have you ever had so much energy that you did not sleep for 2-3 days?				

If you checked off *any* problems, how *difficult* have these problems made it for you to do your school work or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____