

# Screening Questionnaire: Restless Legs Syndrome (Parent Version)

Child's Name: \_\_\_\_\_

Person filling out form: \_\_\_\_\_

1. Does your child have "growing pains"? (Check One)

\_\_\_\_\_ never \_\_\_\_\_ occasionally \_\_\_\_\_ sometimes \_\_\_\_\_ frequently  
(less than 1x/month) (1-2x/month) (1-2x/wk to daily)

2. Does your child complain of uncomfortable or funny feelings (creeping, crawling, tingling) in his/her legs? (Check One)

\_\_\_\_\_ never \_\_\_\_\_ occasionally \_\_\_\_\_ sometimes \_\_\_\_\_ frequently  
(less than 1x/month) (1-2x/month) (1-2x/wk to daily)

	<u>YES</u>	<u>NO</u>	<u>DON'T KNOW</u>
3. Does your child:			
A. Notice funning feelings in his/her legs (or do they seem worse) when lying down or sitting?	_____	_____	_____
B. Have partial relief with movement (wiggling feet, toes, or walking?)	_____	_____	_____
C. Complain that the feelings are worse at night?	_____	_____	_____
D. Have a lot of fidgeting or wiggling of the feet or toes when sitting or lying down?	_____	_____	_____
E. Have repeated jerking movements in toes or legs or the whole body while sleeping?	_____	_____	_____

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From: Mindell JA & Owens JA (2003). *A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems*. Philadelphia: Lippincott Williams & Wilkins.

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4. Does your child appear restless while sleeping (thrashing around, banging feet against wall, twisting covers, or falling out of bed)? (Check One)

\_\_\_\_\_ never \_\_\_\_\_ occasionally \_\_\_\_\_ sometimes \_\_\_\_\_ frequently  
(less than 1x/month) (1-2x/month) (1-2x/wk to daily)

5. Does your child seem more restless, fidgety or hyperactive than most children his/her age?

\_\_\_\_\_ never \_\_\_\_\_ occasionally \_\_\_\_\_ sometimes \_\_\_\_\_ frequently  
(less than 1x/month) (1-2x/month) (1-2x/wk to daily)

6a. Has anyone in the family (including grandparents, aunts/uncles) been diagnosed with restless legs or periodic leg movements during sleep? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, who: \_\_\_\_\_

6b. Does anyone in the family have severe problems falling or staying asleep? If so, who:

\_\_\_\_\_. Type of problem, if known: \_\_\_\_\_

7. How often, on average, does your child consume caffeine-containing beverages or food? (coffee, tea, cola beverages, chocolate)

\_\_\_\_\_ never \_\_\_\_\_ occasionally \_\_\_\_\_ sometimes \_\_\_\_\_ frequently  
(less than 1x/month) (1-2x/month) (1-2x/wk to daily)

8. Has your child ever been diagnosed and/or treated for anemia?

Yes\_\_\_ No\_\_\_ Don't Know\_\_\_

Date, type of anemia, and treatment, if known: \_\_\_\_\_

# Screening Questionnaire: Restless Legs Syndrome (Adolescent Self-Report Version)

Your name: \_\_\_\_\_

1. Have you ever had “growing pains”? (Check one)

\_\_\_\_\_ never    \_\_\_\_\_ occasionally    \_\_\_\_\_ sometimes    \_\_\_\_\_ frequently    \_\_\_\_\_ only in the past  
(less than 1x/month)    (1-2x/month)    (1-2x/wk to daily)

2. Do you have uncomfortable or funny feelings (creeping, crawling, tingling) in your legs? (Check one)

\_\_\_\_\_ never    \_\_\_\_\_ occasionally    \_\_\_\_\_ sometimes    \_\_\_\_\_ frequently    \_\_\_\_\_ only in the past  
(less than 1x/month)    (1-2x/month)    (1-2x/wk to daily)

3. Do you ever:

	<u>YES</u>	<u>NO</u>	<u>DON'T KNOW</u>
A. Notice funning feelings in your legs (or do they seem worse) when lying down or sitting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Have partial relief with movement (wiggling feet, toes, or walking?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Notice that the feeling is worse at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Have a lot of fidgeting or wiggling of your feet or toes when sitting or lying down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Have repeated jerking movements in toes or legs or the whole body while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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