Treatment evaluation tool and treatment goals

	Structured Insomnia follow up questionnaire (over the last month)
Date	Child's name Age
Child's sleep*	1. At what time does your child go to bed? 2. How long does it take your child to fall asleep from lights off? _____ **minutes** 3. After falling asleep about how many times does your child wake up at night (not counting final awakening)? 4. In total, how long do these awakenings last approximately? _____ **minutes** 5. What is approximately the longest episode of continuous sleep / uninterrupted sleep that your child has per night? ____ **hours: minutes** 6. At what time does your child finally wake up for the day? 7. How many hours of actual sleep does your child get during the night? ____ **hours: minutes** 8. Does your child feel tired /rested upon awakening? 9. In total how long does the child nap during the day? _____ **minutes**
Treatment goals	10. Is the response to Q2 **<30** minutes on average? Yes/No 11. Is the response to Q2 >6 hours on average? Yes/No **12.** Is the response to Q7 ≥ 8 (age 2-6) or ≥7 (age 6-18) hours? Yes/No **If one or more answer is No consider treatment/dose adjustment**
Child's behaviors	1. Have you noticed a change in your child's behaviour after they had a good night's sleep? Please list the most important behaviors below • _____ 2. How would you rate this behaviour in the last month or since the last visit?

Score→ Behavior↓	1	2	3	4	5
_____	Markedly deteriorated	Deteriorated	Not changed	improved	Markedly improved
_____	Markedly deteriorated	Deteriorated	Not changed	improved	Markedly improved
_____	Markedly deteriorated	Deteriorated	Not changed	improved	Markedly improved
_____	Markedly deteriorated	Deteriorated	Not changed	improved	Markedly improved

Parent's satisfaction

11. Are you satisfied with your child's sleep?

Completely Dissatisfied (1)	Mostly Dissatisfied (2)	Neither Satisfied nor Dissatisfied (3)	Mostly Satisfied (4)	Completely Satisfied (5)