PEDIATRIC SLEEPINESS SCALE

NAME:_____AGE_____ SEX _____

We would like to know when you feel sleepy. Use the scale on each page to choose the response that fits you best.

It is important that you fill it out by your self - do not have any one help you. There are no right or wrong answers.

Sleepiness Statements

0 =Never 1 = Rarely (less than 3 times a month) 2 = Sometimes (1-2 times a week)

3 = Often (3-4 times a week) 4 = Almost every day (5 or more times a week)

1. I fall asleep during my morning classes _____
2. I fall asleep during the last class of the day. _____
3. I feel drowsy if I ride in a car for longer than 5 minutes. _____
4. I fall asleep at school in my afternoon classes. _____
5. I feel sleepy when I ride in a bus to a school event like a field trip or sports game. _____
6. I feel sleepy in the evening after school. _____
7. In the morning when I am in school , I fall asleep _____
8. I feel sleepy when I do my homework in the evening after school _____
9. I fall asleep when I ride in a bus, car, or train _____
10. During the school day, there are times when I realize that I have just fallen asleep _____
11. I fall asleep when I do schoolwork at home in the evening _____

Add all the numbers together TOTAL 1 _____

ALERTNESS STATEMENTS

1 = Almost Every day 2 = Often 3 = Sometimes 4 = Rarely 5 = Never

1. I go through the whole school day without feeling tired _____
2. I feel wide awake the whole day _____
3. I feel alert during my classes _____
4. When I am in class, I feel wide-awake _____

TOTAL 2 _____

Add both totals together for the final score FINAL SCORE _____