Avelle ORTHODONTICS

PEDIATRIC SLEEP QUESTIONNAIRE

(PSQ)

Patient Name: _____ **Date:** _____

Please answer Yes / No / Don't Know for each question.

SNORING	*Yes*	*No*	*Don't Know*
Does your child snore more than half the time?	☐	☐	☐
Does your child always snore?	☐	☐	☐
Does your child snore loudly?	☐	☐	☐
Does your child have heavy or loud breathing?	☐	☐	☐
Have you ever seen your child stop breathing during the night?	☐	☐	☐
SLEEPINESS			
Does your child wake up feeling unrefreshed?	☐	☐	☐
Does your child have daytime sleepiness?	☐	☐	☐
Does your child fall asleep during the day?	☐	☐	☐
Is your child hard to wake in the morning?	☐	☐	☐
BEHAVIOR / ADHD-TYPE SYMPTOMS			
Does your child have trouble paying attention?	☐	☐	☐
Is your child easily distracted?	☐	☐	☐
Does your child have difficulty organizing tasks?	☐	☐	☐
Does your child fidget?	☐	☐	☐
Does your child interrupt others?	☐	☐	☐
Is your child restless?	☐	☐	☐
MOUTH BREATHING			
Does your child breathe through their mouth during the day?	☐	☐	☐
Does your child have dry mouth in the morning?	☐	☐	☐
Does your child have nasal congestion?	☐	☐	☐
OTHER			
Does your child sweat heavily at night?	☐	☐	☐
Does your child sleep with neck extended?	☐	☐	☐
Does your child grind teeth at night?	☐	☐	☐
Does your child have bedwetting?	☐	☐	☐

Scoring & Interpretation

Score = Yes answers ÷ Total answers **Patient Score:** _____

A score of **0.33 or higher** indicates **HIGH RISK** for sleep-disordered breathing.

This is the key threshold used in pediatric sleep-disordered breathing screening.

Score < 0.33 Low Risk **Score ≥ 0.33 High Risk – Refer for evaluation**