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)

	YES	NO	DON'T KNOW
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?	_____	_____	_____

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:_____

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Screening Questionnaire: Restless Legs Syndrome

(Adolescent Self-Report Version)

Your name: _____

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

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

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

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

3. Do you ever:

	YES	NO	DON'T KNOW
A. Notice funning feelings in your legs (or do they seem worse) when lying down or sitting?	☐	☐	☐
B. Have partial relief with movement (wiggling feet, toes, or walking?)	☐	☐	☐
C. Notice that the feeling is worse at night?	☐	☐	☐
D. Have a lot of fidgeting or wiggling of your 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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