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)

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? ____________________

© 2000 Hasbro Children's Hospital


Supported by an educational grant from Johnson & Johnson
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:

   A. Notice funny feelings in your legs (or do they seem worse) when lying down or sitting?  
      YES  NO  DON’T KNOW

   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?


© 2000 Hasbro Children’s Hospital

Philadelphia: Lippincott Williams & Wilkins.

Supported by an educational grant from Johnson &