

Epworth Sleepiness Scale for Children and Adolescents

ESS – CHAD

(parent/carer to answer)

Your child's name: _____ Today's date: _____

How old is your child? _____ (years) Boy? (___) or Girl? (___) check one space

Over the past month, how likely has your child been to fall asleep while doing the things that are described below (activities)?

Even if your child hasn't done some of these things in the past month, try to imagine how they would have affected him/her.

Use the following scale to choose one number that best describes what has been happening to your child during each activity over the past month. Write that number in the box below.

0 = would never fall asleep

1 = slight chance of falling asleep

2 = moderate chance of falling asleep

3 = high chance of falling asleep

It is important that you answer each question as best you can

Activities	Chance of falling asleep (0 – 3)
Sitting and reading _____	<input type="text"/>
Sitting and watching TV or a video _____	<input type="text"/>
Sitting in a classroom at school during the morning _____	<input type="text"/>
Sitting and riding in a car or bus for about half an hour _____	<input type="text"/>
Lying down to rest or nap in the afternoon _____	<input type="text"/>
Sitting and talking to someone _____	<input type="text"/>
Sitting quietly by himself/herself after lunch _____	<input type="text"/>
Sitting and eating a meal _____	<input type="text"/>

Thank you

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