EPWORTH SLEEPINESS SCALE FOR CHILDREN AND ADOLESCENTS (ESS-CHAD)

After you or child completes this screener, share the responses with your healthcare provider. He or she will use the instructions on the reverse to calculate the score.

Your Name: _____How old are you?_____(years)___ Boy? ___Girl?

Today's Date: _____

Over the past month, how likely have you been able to fall asleep while doing the things that are described below (activities)? Even if you haven't done some of these things in the past month, try to imagine how they would have affected you.

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

Use the following scale to choose the most appropriate number for each situation:

- **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 as you can.

Situations	Chance of falling asleep (0-3)
Sitting and reading:	
Sitting and watching TV or a video:	
Sitting in a classroom at school during the morning:	
Sitting and riding in a car or bus for about half an hour:	
Lying down to rest or nap in the afternoon:	
Sitting and talking to someone:	
Sitting quietly by yourself after lunch:	
Sitting ang eating a meal:	