

--	--

Participant ID

--	--	--

--	--	--	--	--	--

Nickname



**Restoring Insulin Secretion Study
Cleveland Adolescent Sleepiness Questionnaire**

Today's date: (fill-in) ___ / ___ / ___

What is your age? (fill in years) _____

What is your sex? (check one) ___ Female ___ Male

We would like to know about when you might feel sleepy during a usual week. For each statement, mark the circle under the response that best fits with how often it applies to you. It's important to answer them yourself – don't have people help you. There are no right or wrong answers. For example, if we asked "I sleep with a pillow," and the response that best fit how often you sleep with a pillow was "often," you would mark the item as follows:

EXAMPLE	Never (0 times per month)	Rarely (less than 3 times per month)	Sometimes (1-2 times per week)	Often (3-4 times per week)	Almost every day (5 or more times per week)
I sleep with a pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Sleepiness Questions

	Never (0 times per month)	Rarely (less than 3 times per month)	Sometimes (1-2 times per week)	Often (3-4 times per week)	Almost every day (5 or more times per week)
1. I fall asleep during my morning classes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I go through the whole school day without feeling tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I fall asleep during the last class of the day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I feel drowsy if I ride in a car for longer than five minutes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I feel wide-awake the whole day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I fall asleep at school in my afternoon classes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

		-			
--	--	---	--	--	--

Participant ID

--	--	--	--	--	--

Nickname

	Never (0 times per month)	Rarely (less than 3 times per month)	Sometimes (1-2 times per week)	Often (3-4 times per week)	Almost every day (5 or more times per week)
7. I feel alert during my classes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I feel sleepy in the evening after school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I feel sleepy when I ride in a bus to a school event like a field trip or sports game	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. In the morning when I am in school, I fall asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. When I am in class, I feel wide-awake	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I feel sleepy when I do my homework in the evening after school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I feel wide awake the last class of the day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I fall asleep when I ride in a bus, car, or train	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. During the school day, there are time when I realize that I have just fallen asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I fall asleep when I do my schoolwork at home in the evening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

		-			
--	--	---	--	--	--

Participant ID

--	--	--	--	--	--

Nickname



**Restoring Insulin Secretion Study
Sleep Disturbances Scale for Children**

Instructions: This questionnaire will allow your doctor to have a better understanding of the sleep-wake rhythm of your child and of any problems in his/her sleep behavior. As the parent/guardian of the child, please complete this questionnaire with assistance from the child, as needed. Try to answer every question; in answering, consider each question as pertaining to **past 6 months** of the child's life. Please answer the questions by circling or striking the number ① to ⑤.

Age: _____

Date: _____

1. How many hours of sleep does your child get on most nights?	① 9-11 hrs	② 8-9 hrs	③ 7-8 hrs	④ 5-7 hrs	⑤ less than 5 hrs
2. How long after going to bed does your child usually fall asleep?	① less than 15 min	② 15-30 min	③ 30-45 min	④ 45-60 min	⑤ more than 60 min

①	Never
②	Occasionally (once or twice per month or less)
③	Sometimes (once or twice per week)
④	Often (3-5 times per week)
⑤	Always (daily)

3. The child goes to bed reluctantly	①	②	③	④	⑤
4. The child has difficulty getting to sleep at night	①	②	③	④	⑤
5. The child feels anxious or afraid when falling asleep	①	②	③	④	⑤
6. The child startles or jerks parts of the body while falling asleep	①	②	③	④	⑤
7. The child shows repetitive actions such as rocking or head banging while falling asleep	①	②	③	④	⑤
8. The child experiences vivid dream-like scenes while falling asleep	①	②	③	④	⑤
9. The child sweats excessively while falling asleep	①	②	③	④	⑤
10. The child wakes up more than twice per night	①	②	③	④	⑤
11. After waking up in the night, the child has difficulty to fall asleep again	①	②	③	④	⑤
12. The child has frequent twitching or jerking of legs while asleep or often changes position during the night or kicks the covers off the bed	①	②	③	④	⑤
13. The child has difficulty in breathing during the night	①	②	③	④	⑤
14. The child gasps for breath or is unable to breathe during sleep	①	②	③	④	⑤
15. The child snores	①	②	③	④	⑤
16. The child sweats excessively during the night	①	②	③	④	⑤
17. You have observed the child sleepwalking	①	②	③	④	⑤
18. You have observed the child talking in his/her sleep	①	②	③	④	⑤
19. The child grinds teeth during sleep	①	②	③	④	⑤
20. The child wakes from sleep screaming or confused to that you cannot seem to get through to him/her, but has no memory of these events the next morning	①	②	③	④	⑤
21. The child has nightmares which he/she doesn't remember the next day	①	②	③	④	⑤
22. The child is unusually difficult to wake up in the morning	①	②	③	④	⑤
23. The child awakes in the morning feeling tired	①	②	③	④	⑤
24. The child feels unable to move when waking up in the morning	①	②	③	④	⑤
25. The child experiences daytime somnolence	①	②	③	④	⑤
26. The child falls asleep suddenly in inappropriate situations	①	②	③	④	⑤

This form was completed by: ___Parent/Guardian ___RISE Participant ___Other (Describe _____)

		-			
--	--	---	--	--	--

Participant ID

--	--	--	--	--	--

Nickname



Restoring Insulin Secretion Study
Sleep Disturbances Scale for Children/Adolescents

Instructions: This questionnaire will allow your doctor to have a better understanding of your sleep-wake rhythm and any problems in your sleep behavior. Try to answer every question; in answering, consider each question as pertaining to **past 6 months** of your life. Please answer the questions by circling or striking the number ① to ⑤.

Age: _____

Date: _____

1. How many hours of sleep do you get on most nights?	① 9-11 hrs	② 8-9 hrs	③ 7-8 hrs	④ 5-7 hrs	⑤ less than 5 hrs
2. How long after going to bed do you usually fall asleep?	① less than 15 min	② 15-30 min	③ 30-45 min	④ 45-60 min	⑤ more than 60 min

①	Never
②	Occasionally (once or twice per month or less)
③	Sometimes (once or twice per week)
④	Often (3-5 times per week)
⑤	Always (daily)

3. I go to bed reluctantly	①	②	③	④	⑤
4. I have difficulty getting to sleep at night	①	②	③	④	⑤
5. I feel anxious or afraid when falling asleep	①	②	③	④	⑤
6. I startle or jerk parts of the body while falling asleep	①	②	③	④	⑤
7. I show repetitive actions such as rocking or head banging while falling asleep	①	②	③	④	⑤
8. I experience vivid dream-like scenes while falling asleep	①	②	③	④	⑤
9. I sweat excessively while falling asleep	①	②	③	④	⑤
10. I wake up more than twice per night	①	②	③	④	⑤
11. After waking up in the night, I have difficulty to fall asleep again	①	②	③	④	⑤
12. I have frequent twitching or jerking of legs while asleep or often change position during the night or kick the covers off the bed	①	②	③	④	⑤
13. I have difficulty in breathing during the night	①	②	③	④	⑤
14. I gasp for breath or am unable to breathe during sleep	①	②	③	④	⑤
15. I snore	①	②	③	④	⑤
16. I sweat excessively during the night	①	②	③	④	⑤
17. I sleepwalk	①	②	③	④	⑤
18. I talk in my sleep	①	②	③	④	⑤
19. I grind teeth during sleep	①	②	③	④	⑤
20. I wake from sleep screaming or confused, but have no memory of these events the next morning	①	②	③	④	⑤
21. I have nightmares which I don't remember the next day	①	②	③	④	⑤
22. I am unusually difficult to wake up in the morning	①	②	③	④	⑤
23. I awake in the morning feeling tired	①	②	③	④	⑤
24. I feel unable to move when waking up in the morning	①	②	③	④	⑤
25. I experience daytime somnolence	①	②	③	④	⑤
26. I fall asleep suddenly in inappropriate situations	①	②	③	④	⑤

This form was completed by: ___Parent/Guardian ___RISE Participant ___Other (Describe _____)