Iowa Sleep DISORDERS CENTER

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

Your Name: _____ **DOB:** _____ **Age:** ____ **Boy ☐ Girl ☐ Today's Date** _____

Over the past month, how likely have you been 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 a 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.

Activity	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 and eating a meal	_____
	=_____ **Total Score**