BISQ – Sleep questionnaire for infants

Please mark only one (most appropriate) choice, when you respond to items with a few options.

Name of Responder: ______________________ Date: __________
Role of Responder: ☐ Father ☐ Mother ☐ Grandparent ☐ Other, Specify: _________
Name of the child: _____________ Date of Birth: Month _____ Day: _____ Year: _____
Sex: ☐ Male ☐ Female Birth order of the child: ☐ Oldest ☐ Middle ☐ Youngest
Sleeping arrangement:
☐ Infant crib in a separate room ☐ Infant crib in parents' room
☐ In parents' bed ☐ Infant crib in room with sibling
☐ Other, Specify: _____________
In what position does your child sleep most of the time?
☐ On his/her belly ☐ On his/her side ☐ On his/her back
How much time does your child spend in sleep during the NIGHT (between 7 in the evening and 7 in the morning)? Hours: _____ Minutes: _____
How much time does your child spend in sleep during the DAY (between 7 in the morning and 7 in the evening)? Hours: _____ Minutes: ______
Average number of night wakings per night: ___________
How much time during the night does your child spend in wakefulness (from 10 in the evening to 6 in the morning)? Hours: _____ Minutes: _____
How long does it take to put your baby to sleep in the evening?
Hours: _____ Minutes: _____
How does your baby fall asleep?
☐ While feeding ☐ Being rocked ☐ Being held
☐ In bed alone ☐ In bed near parent
When does your baby usually fall asleep for the night:
Hours: _____ Minutes: _____
Do you consider your child's sleep as a problem?
☐ A very serious problem ☐ A small problem ☐ Not a problem at all