**The baby sleep survey**

We would like your help learning about babies sleep. This survey is divided into three parts.

**Prescreening** - You have already provided this information

**Day 1 -** This partasks you to sign some forms and for some general background information. it should only take about 20 minutes to fill. You should complete this straight-away

* + **Goldsmiths consent form**
  + **IPSOS Confidentiality agreement**
  + **Background information & baby temperament questionnaire.**

**Weekly -** A few short questions that we like you to fill in each morning for three weeks.

* **Week 1 - 7 night sleep diary, nappy type 1**
* **Week 2 - 7 night sleep diary, nappy type 2**
* **Week 3 - 7 night sleep diary, nappy type 3**

All the information you provide us with will be treated as confidential, and analysed anonymously. You and your child will not be individually identified.

Please tick the boxes and sign below to confirm that you have read and understood the above information about this questionnaire and have had the opportunity to ask questions. By checking this you indicate that you understand that participation is voluntary and that you are free to withdraw at any time, without giving any reason, without your legal rights being affected.

 I understand this information and am happy to take part

 I am happy for my written answers and comments to be used anonymously

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your participation is much appreciated!

Dr Caspar Addyman, University of London, [c.addyman@gold.ac.uk](mailto:c.addyman@gold.ac.uk)

**Background information**

SECTION 1 - BASIC INFORMATION

Name of Responder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Role of Responder: [ ] Mother [ ] Father [ ] Grandparent [ ] Other : \_\_\_\_\_\_\_\_\_\_

Name of the child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex of child: [ ] Male [ ] Female

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_

Was child born prematurely: [ ] No [ ] Yes If yes, how many weeks? : \_\_\_\_\_\_\_\_\_\_

Immediately after birth, did child spend any time in an intensive care unit?: [ ] No [ ] Yes

Does the child have any current medical problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a list all child’s brothers and sisters by age (e.g. Sister 11 years, Brother 3 years, etc)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Number of people in household: \_\_\_\_\_\_\_\_\_\_

Number of children (under 16) in household: \_\_\_\_\_\_\_\_\_\_

SECTION 2 - INFANT GENERAL SLEEP INFORMATION

Sleeping arrangement (pick one):

[ ] Infant crib in a separate room [ ] Infant crib in parents’ room

[ ] Infant crib in room with sibling [ ] In parents’ bed

[ ] Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your baby have a bedtime routine? (pick one)

[ ] Yes [ ] Kind of [ ] Not yet

In what position does your child sleep most of the time?

[ ] On his/her belly [ ] On his/her side [ ] On his/her back

How does your baby normally fall asleep at night? (pick one)

[ ] While feeding [ ] Being rocked [ ] Being held

[ ] In bed alone [ ] In bed near parent

How do you normally put your baby into bed?

[ ] Awake [ ] Asleep

|  |  |
| --- | --- |
|  | Answer in  [ Hours : Minutes ] |
| How much time does your child spend in sleep during the NIGHT? | [ \_\_\_\_:\_\_\_\_ ] |
| How much time does your child spend in sleep during the DAY? | [ \_\_\_\_:\_\_\_\_ ] |
| How much time during the NIGHT does your child spend awake? | [ \_\_\_\_:\_\_\_\_ ] |
| How long does it take to put your baby to sleep in the evening? | [ \_\_\_\_:\_\_\_\_ ] |
| When does your baby usually fall asleep for the night? | [ \_\_\_\_:\_\_\_\_ ] |

Average number of night wakings per night: \_\_\_\_\_\_\_\_\_\_\_\_

In your opinion what makes your child wake up at night on normal days ?

[ ] Feeding [ ] Changing Diaper [ ] Illness

[ ] Teething [ ] Vaccination

[ ] Other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you normally need to change diaper during the night? [ ] Yes [ ] No

Which brand did you buy most often in the last 3 months?

[ ] Pampers [ ] Huggies [ ] Capricho

[ ] ??????? [ ] ?????? [ ] Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does changing his or her diaper help your child go back to sleep? [ ] Yes [ ] No

Average number of naps during the DAY: \_\_\_\_\_\_\_\_\_\_\_\_

Average length of naps during the DAY: [ \_\_\_\_:\_\_\_\_ ]

Who provides daytime care for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When does your child sleep better (at night)?

[ ] After an active day [ ] After a calm day

When does your child sleep better (at night)?

[ ] After many daily naps [ ] After few / no naps

Do you consider your child’s sleep as a problem?

[ ] A serious problem

[ ] A small problem

[ ] Not a problem at all

Do you satisfied with your child’s sleep?

[ ] Yes [ ] No [ ] Unsure

Do you experience a lack of sleep, which impacts your daily acitivites?

[ ] Yes [ ] No [ ] Sometimes

Any general comments about your child’s sleep and how it affects you or your child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECTION 3 - Infant Behaviour

As you read each description of the baby’s behavior below, please indicate how often the baby did this during the LAST WEEK (the past seven days) by circling one of the numbers in the left column. These numbers indicate how often you observed the behavior described during the last week.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Never** | **Very Rarely** | **Less Than Half the Time** | **About Half the Time** | **More Than Half the Time** | **Almost Always** | **Always** | **Does Not Apply** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **-** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Never |  |  | Half the time |  |  | Always | Does not apply |
| **1.** When being dressed or undressed during the last week, how often did the baby squirm  and/or try to roll away? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **2.** When tossed around playfully how often did the baby laugh? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **3.** When tired, how often did your baby show distress? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **4.** When introduced to an unfamiliar adult, how often did the baby cling to a parent? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| 5. How often during the last week did the baby enjoy being read to? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **6.** How often during the last week did the baby play with one toy or object for 5-10 minutes? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **7.** How often during the week did your baby move quickly toward new objects? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **8.** When put into the bath water, how often did the baby laugh? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **9.** When it was time for bed or a nap and your baby did not want to go, how often did s/he whimper or sob? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **10.** After sleeping, how often did the baby cry if someone doesn’t come within a few minutes? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **11.** In the last week, while being fed in your lap, how often did the baby seem eager to  get away as soon as the feeding was over? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **12.** When singing or talking to your baby, how often did s/he soothe immediately? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **13.** When placed on his/her back, how often did the baby squirm and/or turn body? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **14.** During a peekaboo game, how often did the baby laugh? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **15.** How often does the infant look up from playing when the telephone rings? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **16.** How often did the baby seem angry (crying and fussing) when you left her/him in the crib? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **17.** How often during the last week did the baby startle at a sudden change in body  position (e.g., when moved suddenly)? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **18.** How often during the last week did the baby enjoy hearing the sound of words, as in nursery rhymes? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **19.** How often during the last week did the baby look at pictures in books and/or  magazines for 5 minutes or longer at a time? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **20.** When visiting a new place, how often did your baby get excited about exploring new surroundings? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **21.** How often during the last week did the baby smile or laugh when given a toy? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **22.** At the end of an exciting day, how often did your baby become tearful? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **23.** How often during the last week did the baby protest being placed in a confining place  (infant seat, play pen, car seat, etc.)? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **24.** When being held, in the last week, did your baby seem to enjoy him/herself? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **25.** When showing the baby something to look at, how often did s/he soothe immediately? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **26.** When hair was washed, how often did the baby vocalize? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **27.** How often did your baby notice the sound of an airplane passing overhead? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **28.** When introduced to an unfamiliar adult, how often did the baby refuse to go to the  unfamiliar person? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **29.** When you were busy with another activity, and your baby was not able to get your attention, how often did s/he cry? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **30.** How often during the last week did the baby enjoy gentle rhythmic activities, such as  rocking or swaying? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **31.** How often during the last week did the baby stare at a mobile, crib bumper or picture  for 5 minutes or longer? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **32.** When the baby wanted something, how often did s/he become upset when s/he could  not get what s/he wanted? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **33.** When in the presence of several unfamiliar adults, how often did the baby cling to a parent? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **34.** When rocked or hugged, in the last week, did your baby seem to enjoy him/herself? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **35.** When patting or gently rubbing some part of the baby’s body, how often did s/he  soothe immediately? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **36.** How often did your baby make talking sounds when riding in a car? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |
| **37.** When placed in an infant seat or car seat, how often did the baby squirm and turn body? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **-** |

**SLEEP DIARY SUMMARY**

**WEEK 1**

**DATE OF 1ST MORNING** \_\_\_\_\_\_\_\_\_ **DAY OF WEEK?** \_\_\_\_\_\_\_\_\_

**NAPPY PRODUCT CODE** \_\_\_\_\_\_\_\_\_

**WEEK 2**

**DATE OF 1ST MORNING** \_\_\_\_\_\_\_\_\_ **DAY OF WEEK?** \_\_\_\_\_\_\_\_\_

**NAPPY PRODUCT CODE** \_\_\_\_\_\_\_\_\_

**WEEK 3**

**DATE OF 1ST MORNING** \_\_\_\_\_\_\_\_\_ **DAY OF WEEK?** \_\_\_\_\_\_\_\_\_

**NAPPY PRODUCT CODE** \_\_\_\_\_\_\_\_\_

SLEEP DIARY

*Please answer these following questions each morning. You should fill it in after your baby has woken up and you have got ready for the day. You can fill this in any time but the sooner you complete it after your morning routine is complete the better.*

*Answers do not have to be exact. Just give your best guess.*

*If you are away from home or if you or your child are poorly please mention this in the Any Other Comments section*

**SLEEP DIARY**

**WEEK 1 2 3**  **Day 1 2 3 4 5 6 7 (circle)**

ABOUT YOUR BABY’S NIGHT

|  |  |
| --- | --- |
| What time did your baby go to sleep last night? | [ \_\_\_\_:\_\_\_\_ ] |
| What time did your baby wake up this morning? | [ \_\_\_\_:\_\_\_\_ ] |
| How many times did your baby wake up in the night? |  |

How did your baby fall asleep? (pick one)

[ ] While feeding [ ] Being rocked [ ] Being held

[ ] In bed alone [ ] In bed near parent

Did you feed your baby during the night?

[ ] No [ ] Yes [ ] More than once: \_\_\_\_\_\_

Did you change your baby’s diaper during the night?

[ ] No [ ] Yes

If yes, why

[ ] Leakage [ ] I always do it [ ] Baby was crying

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any disturbances in the night?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABOUT YOUR BABY’S MORNING

This morning was your baby’s diaper (pick one)?

[ ] Dry [ ] Wet [ ] Soiled

Were there any (pick all that apply)?

[ ] Leakages [ ] Skin dryness [ ] Red skin

[ ] Pressure marks

How energetic was your baby?

Very Tired Very Energetic

0 ---- 1 ---- 2---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

How Happy was your baby?

Very Unhappy Very Happy

0 ---- 1 ---- 2---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

How giggly was your baby?

Very Serious Very Giggly

0 ---- 1 ---- 2---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

What was the first thing (if any) to make your baby laugh?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other notes about your child’s day yesterday (any new skills obtained, any unusual things)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABOUT YOUR NIGHT

|  |  |
| --- | --- |
| What time did you get into bed? | [ \_\_\_\_:\_\_\_\_ ] |
| What time did you try to sleep? | [ \_\_\_\_:\_\_\_\_ ] |
| How many times were you woken by your baby? |  |
| How many other times did you wake up, not counting your final awakening? |  |
| What time was your final awakening? | [ \_\_\_\_:\_\_\_\_ ] |
| What time did you get out of bed for the day? | [ \_\_\_\_:\_\_\_\_ ] |

How would you rate the quality of your sleep?

Very Poor Very Good

0 ---- 1 ---- 2---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

How energetic were you?

Very Tired Very Energetic

0 ---- 1 ---- 2---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

How Happy were you?

Very Unhappy Very Happy

0 ---- 1 ---- 2---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

Any other comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_