Rhythmic Movement Disorder Questionnaire

Structured interview for diagnosis of sleep-related rhythmic movement disorder in children. Questionnaire is to be filled out by the parent.

1. Does your child usually show repetitive actions such as body rocking or head banging while falling asleep at the beginning of the night?
   - [ ] Yes
   - [ ] No

   1a. If YES, how long do they last? ________________

2. Does your child usually have these movements during the night AFTER they have fallen asleep?
   - [ ] Yes
   - [ ] No
   - [ ] Don’t know

   2a. If YES, how long do they last? ________________

   2b. Is your child awake when he/she has these movements during the night? (i.e. do they respond to you)
      - [ ] Yes
      - [ ] No
      - [ ] Don’t know

3. Are the movements while asleep different to the movements while awake and falling asleep?
   - [ ] Yes
   - [ ] No
   - [ ] Not applicable (no movements during sleep, only while awake and falling asleep)

   3a. If YES, how are the movements different?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

4. Does your child have these movements during the day, when fully awake? (Not during nap time)
   - [ ] Yes, frequently
   - [ ] Yes, occasionally
   - [ ] No

5. Does your child have daytime naps?
   - [ ] Yes
   - [ ] No

   If NO, go to Question 7.

6. If YES in Question 5, does your child have these movements and when does it happen?
   - [ ] Yes
   - [ ] No

   6a. If YES, when do they happen?
      - [ ] At the beginning of a nap
      - [ ] Later on during the nap after they have first fallen asleep
7. What type of movement does your child show?  
*You can choose multiple suitable answers

☐ Head banging *(head forcibly moved and strikes against an object)*  
☐ Body rocking *(whole body is rocked)*  
☐ Head rolling *(head is moved side to side)*  
☐ Body rolling  
☐ Leg rolling  
☐ Leg banging  
☐ Arm banging  
☐ Other: __________________________

8. When your child is doing these movements, is your child

☐ Sitting up  
☐ On all fours  
☐ Lying down?

9. If LYING DOWN in question 8, is your child on their front (prone) or back (supine) when doing these movements?

☐ On his/her front (prone)  
☐ On his/her back (supine)  
☐ Not applicable as not lying down

10. Body rocking - does your child rock:

☐ Forwards and backwards  
☐ Up and down  
☐ Other: __________________________

11. Does a part of their body strike an object?

☐ Yes  ☐ No

11a. If YES, which part of the body?

☐ Head – top  ☐ Arm  
☐ Head – forehead  ☐ Leg  
☐ Head - back of head  ☐ Other: __________________________

11b. If YES, what does it strike?

☐ Pillow  ☐ Wall  
☐ Solid bed head  ☐ Other: __________________________  
☐ Mattress

12. Has the repetitive movement caused
13. On average how many episodes of movements do they have in a night?  
*(NOT including the movement at the beginning)*

14. How long do the repetitive movements last while asleep?  
- Less than 10 minutes  
- 10 to 20 minutes  
- 20 minutes to 1 hour  
- More than an hour  
- Don't know  
- Not applicable (no movements during sleep)

15. Does your child make any spontaneous sounds during the movements?  
- Yes  
- No  

15a. If YES, please describe_______________________________

16. If your child has movements during sleep, when in the night do they do the movements?  
- Mostly First half of the night  
- Mostly Second half of the night  
- Not applicable

17. How old was your child when you first noticed the movements?  
   ________year(s) ________month(s)

18. Do you think the repetitive movements have an impact on your child during the day?  
- Yes  
- No  

18a. If YES, how does it affect your child?  
   ____________________________

19. Do you think the movements affect your child's sleep quality?  
- Yes, very much  
- Yes, a little  
- Not sure  
- No, not really  
- Definitely not at all

20. Do the movements stop anyone else from going to sleep, or wake them up?  
- Yes  
- No
<table>
<thead>
<tr>
<th>21. Regarding the movements</th>
<th>Yes, very much</th>
<th>Yes, a little</th>
<th>Not sure</th>
<th>No, not really</th>
<th>Definitely not at all</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Do they affect the parent 1’s sleep quality</td>
<td>☐</td>
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<tr>
<td>Do they affect the parent 2’s sleep quality</td>
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<td>Do they affect the sleep quality of sibling 1 (oldest)</td>
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<td>Do they affect the sleep quality of sibling 2?</td>
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<td>Do they affect the sleep quality of sibling 3</td>
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<tr>
<td>Do they affect the sleep quality of sibling 4</td>
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<tr>
<td>Do they affect the sleep quality of others?</td>
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<tr>
<th>22. Regarding the movements</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
<th>If yes, please describe</th>
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</thead>
<tbody>
<tr>
<td>Do they affect the parent 1’s daytime wellbeing?</td>
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23. Prior to sleep clinic did you seek any advice about the repetitive movements?

☐ Yes  ☐ No

If YES, answer the following questions. If NOT, move to question 24

23a. Where from?

☐ Professional advice, please state which professional ______________
☐ Friends, family
☐ Internet, books, magazines
☐ Other ______________

23b. What advice were you given, and who was this from?

________________________________________________________________________________

________________________________________________________________________________

23c. What have you tried? (Please describe the changes you made)

<table>
<thead>
<tr>
<th>Changing the physical environment of the child’s bedroom</th>
<th>Did it help?</th>
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</thead>
<tbody>
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<td>Bed</td>
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<td>☐ Yes  ☐ No</td>
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<tr>
<td>Bedding</td>
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<tr>
<td>☐ Yes  ☐ No</td>
<td>☐ Yes  ☐ No</td>
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<tr>
<td>Bedroom</td>
<td></td>
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<tr>
<td>☐ Yes  ☐ No</td>
<td>☐ Yes  ☐ No</td>
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<tr>
<td>Other</td>
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<tr>
<td>☐ Yes  ☐ No</td>
<td>☐ Yes  ☐ No</td>
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</table>

Using behavioural modification

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<tr>
<th>Did it help?</th>
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<tr>
<td>☐ Yes  ☐ No</td>
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Using medications

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<th>Did it help?</th>
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<td>☐ Yes  ☐ No</td>
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If YES, what was the drug(s)?

_________________
23d. If there was a change, what did you notice? (Tick all that apply)

- Movements stopped permanently
- Movements stopped temporarily
- Movements reduced in frequency or intensity
- No difference at all
- Movements increased

24. Overall, how concerned are you about your child’s repetitive movements?

- Very concerned
- A little concerned
- Not sure
- Not really concerned
- Definitely not at all

24a. If you are concerned, please say more about what concerns you.

__________________________________________________________________________
__________________________________________________________________________

24b. Have you ever been concerned about:

- Your child hurting themselves
- The movements affecting their sleep
- The movements not going away
- Other worries: __________________________________________________________

25. Have you had any thoughts about what might have caused this?

__________________________________________________________________________

26. Has any relative of the child ever had repetitive movements relating to sleep?

- No  □ Yes, IF YES

26a. How were they related?

__________________________________________________________________________

26b. What type of movements did they have?

__________________________________________________________________________

26c. Did they stop in childhood?

__________________________________________________________________________

26d. If so at what age?

__________________________________________________________________________