Sleep Clinic Questionnaire[[1]](#footnote-1)

[www.sleepontario.com](http://www.sleepontario.com)

Name: Enter

Address: Enter

Telephone:

Home: Enter

Work: Enter

E-Mail: Enter

Family doctor: Enter

Address: Enter

Telephone: Enter

Fax: Enter

Email: Enter

Other physicians who should be informed about your sleep assessment (*please indicate names and addresses*):

Enter

Health card number: Enter Version code: Enter

Age: Enter Occupation: Enter Gender: Choose

Marital status: Choose

Date of birth:

Day: Enter Month: Enter Year: Enter

What time are you completing this questionnaire?

Time of day: Enter Date: Pick date

# Let’s Begin

Please identify your main reason for this consultation:

Problem with sleep

Difficulty when awake

Disturbing the sleep of bed partner

Other (*Please specify*): Enter

Who initiated the referral to our clinic?

Myself My family doctor

A family member Other specialist

A friend Other health care professional

Please briefly describe your current sleep difficulty, concern or other problem:

Enter

What are you hoping to achieve from coming to this clinic?

Enter

Please list your medical history: Have you had any of the following problems? (*check all that apply*)

|  |  |  |
| --- | --- | --- |
| ☐Angina | ☐ Heartburn (GE reflux) | ☐ Depression |
| ☐ Asthma | ☐ Heart disease | ☐ Anxiety |
| ☐ Arthritis (chronic stiffness/pain)  ☐ Back problems | ☐ Hypertension (high blood  pressure) | ☐ Seizure  ☐ Stroke |
| ☐ Coronary artery bypass surgery | ☐ Kidney or liver disease | ☐ Hyperthyroid |
| ☐ Chronic fatigue syndrome | ☐ Leg cramps while asleep | ☐ Hypothyroid |
| ☐ Diabetes | ☐ Loss of consciousness | ☐ Other (*list*): |
| ☐ Emphysema | ☐ Migraine headaches | Enter |
| ☐ Fibromyalgia syndrome | ☐ Parkinson’s disease | Enter |
| ☐ Head trauma | ☐ Post-nasal drip | Enter |

Please list your history of any surgeries:

Enter

Please list all the medications that you are taking and the doses:

|  |  |  |
| --- | --- | --- |
| 1. Enter | 4. Enter | 7. Enter |
| 2. Enter | 5. Enter | 8. Enter |
| 3. Enter | 6. Enter | 9. Enter |

Are you allergic to any medication? Choose

If yes, please list: Enter

List herbal remedies that you are taking: Enter

Do you exercise regularly? Choose

If yes, at what time of day typically? Enter

How often? Enter How long each time (on average)? Enter

On average, how much alcohol do you drink per week? *(If less than one drink per day, enter 0)*

Enter cans of beer Enter glasses of wine Enter ounces of liquor

On average, how much caffeine do you take in each day?

Enter cans of coffee Enter cups of tea Enter cans of cola Enter slabs of chocolate

Do you presently smoke cigarettes? Choose

If yes, number? Enter

If not a current smoker, have you smoked in the past? Choose

If yes, when? Enter

Do you use any recreational drugs (*marijuana, etc*)? Choose

If yes, which? Enter

Are you addicted in any way to over the counter medication? Choose

If yes, please list: Enter

Are you addicted to prescription medication? Choose

If yes, please give list: Enter

Do you experience recurrent episodes of strong desires to eat, lasting for several days (2-3 times/years) in direct association with severe sleepiness? (*answer yes if these episodes occur only when sleepy, and the urges resolve when not sleepy*) Choose

Have you ever been exposed to an extreme heat stress? (*e.g.: falling asleep in a sauna*) Choose

# NRSS (Non-restorative Sleepiness scale): Questionnaire

**Please select the response that best represents your usual experiences over the past month.**

How often have you felt really refreshed upon awakening in the morning?

Never 1 day/week 2-3 days/week 4-5 days/week 6-7 days/week

1. How would you rate the quality of your sleep?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Very poor* | |  |  |  |  |  |  | *Very good* | |

2. Usually, do you think your sleep is restoring or refreshing?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Never* | |  |  |  |  |  |  | *Always* | |

3. Have you felt rested if you’ve slept for your usual amount of time?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Not at all* | |  |  |  |  |  |  | *Absolutely* | |

4. Have you had physical sensations or unusual feelings in your body that you couldn’t identify?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Never* | |  |  |  |  |  |  | *Yes, all the time* | |

5. In the past month, how often have you had one or more of the following:headaches, body pain, numbness or tingling in parts of your body, nausea, racing heart/palpitations, sore throat, frequent cough?

****Never ****1 day/week ****2-3 days/week ****4-5 days/week ****6-7 days/week

6. Do you feel that physical or medical problems are dragging you down?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Never* | |  |  |  |  |  |  | *Yes, all the time* | |

7. Do you ever have a sense of panic, or physical symptoms of panic such as heart racing, for no apparent reason?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Never* | |  |  |  |  |  |  | *Yes, all the time* | |

8. How is your memoryand concentration during the daytime?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Very poor* | |  |  |  |  |  |  | *Very good* | |

9. What is your usual level of daytime energy?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Very low* | |  |  |  |  |  |  | *Very high* | |

10. Do you usually feel alert during the daytime?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Not at all* | |  |  |  |  |  |  | *Very alert* | |

11. Do you feel depressed or down if you didn’t sleep well the night before?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| *Not at all* | |  |  |  |  |  |  | *Very depressed* | |

12. How often have you felt irritable or gotten the “blahs” if you didn’t sleep well the night before?

****Never ****1 day/week ****2-3 days/week ****4-5 days/week ****6-7 days/week

# Toronto Sleepiness and Fatigue Scale (TSFS)

*Please select the appropriate number for both the sleepy and fatigue score for each question. While answering the following questions please keep this in mind:*

**0** = not at all sleepy or fatigued **1** = mildly sleepy or fatigued

**2** = somewhat sleepy or fatigued **3** = very sleepy or fatigued

**How sleepy or fatigued would you feel today if:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Situation | Sleepy | Fatigued |
| 1 | You worked on the computer for four hours? | Choose | Choose |
| 2 | You were a passenger in a non-stop 1-hour drive? | Choose | Choose |
| 3 | You had 2 hours less sleep than normal? | Choose | Choose |
| 4 | You received disheartening news? | Choose | Choose |
| 5 | You had a draining and unproductive 3-hour shopping experience? | Choose | Choose |
| 6 | You had an intense 2 hours phone conversation? | Choose | Choose |
| 7 | You were to listen to a boring speech or lecture for 1 hour? | Choose | Choose |
| 8 | You had an intensive one-hour workout? | Choose | Choose |
| 9 | You went to watch an indifferent movie in the theatres? | Choose | Choose |
| 10 | You did nothing for an entire afternoon? | Choose | Choose |

# Insomnia Severity Index

1. Please rate the current severity of your insomnia problem(s):

|  |  |
| --- | --- |
| Difficulty falling asleep | Choose |
| Difficulty staying asleep | Choose |
| Problem waking up too early | Choose |

2. How satisfied/dissatisfied are you with your current sleep pattern?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Very satisfied |  | Moderately satisfied |  | Very dissatisfied |
| 0 | 1 | 2 | 3 | 4 |

3. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime functioning, ability to function at work/daily chores, concentration, memory, mood, etc.)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | A little | Somewhat | Much | Very much |
| 0 | 1 | 2 | 3 | 4 |

4. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | A little | Somewhat | Much | Very much |
| 0 | 1 | 2 | 3 | 4 |

5. How WORRIED/DISTRESSED, are you about your current sleep problem?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | A little | Somewhat | Much | Very much |
| 0 | 1 | 2 | 3 | 4 |

After a poor night’s sleep, which of the following problems do you experience the next day? (*Check all those that apply*)

|  |  |
| --- | --- |
| ☐ | 1. Daytime fatigue: tired, exhausted, washed out, sleepy. |
| ☐ | 1. Difficulty functioning: performance impairment at work/daily chores, difficulty concentrating, memory problems. |
| ☐ | 1. Mood problems: irritable, tense, nervous, groggy, depressed, anxious, grouchy, hostile, angry, confused. |
| ☐ | 1. Physical symptoms: muscle aches/pain, light-headedness, headache, nausea, heartburn, muscle tension. |
| ☐ | 1. None. |

# SYMPTOMS

*The following is a list of symptoms that you may have had in the recent past.*

*Select the appropriate number, using this scale:*

|  |  |
| --- | --- |
| ***1*** *= Have the symptoms RIGHT NOW* | ***3*** *= Have EVER had the symptoms* |
| ***2*** *= Have had in the LAST YEAR but not right now* | ***4*** *= Have NEVER had and not right now* |

|  |  |
| --- | --- |
| Sensitivity to hot/cold | Choose |
| Inability to stand heat | Choose |
| Inability to stand cold | Choose |
| Brittle nails | Choose |
| Change in hair | Choose |
| Dry skin | Choose |
| Chest pain | Choose |
| Missing/irregular heart beats | Choose |
| Heart “racing” | Choose |
| Palpitation/heart flutter | Choose |
| Heart pain | Choose |
| Recurrent sore throat | Choose |
| Lump in your throat | Choose |
| Mouth sores/painful gums | Choose |
| Hot flashes | Choose |
| Sweating | Choose |
| Unexplained weight loss | Choose |
| Tired with no reason/fatigued | Choose |
| Loss of taste | Choose |
| Frequent cough | Choose |

Please Select “YES” or “NO” as appropriate:

|  |  |
| --- | --- |
| While laughing, or if suddenly excited, do you suddenly lose muscle control or lose strength in your face, arms and/or legs? | Choose |
| On occasion, do you awaken soon after going to sleep or in the morning actually feeling paralyzed, unable to move or unable to talk, which lasts only a few seconds or minutes? | Choose |
| Are your dreams so real you cannot tell if you are asleep or awake? | Choose |

# ILLNESS INTRUSIVENESS RATING SCALE

*Please select the number that best describes your current life situation. If an item is not applicable, please select the number (1) to indicate that this aspect of your life is not affected very much. Please do not leave any items unanswered.*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| How much does your sleep problem and/or its treatment interfere with you? | | | | | | | | | |
|  | Not very much | | |  | | | Very much | | |
| 1. Health | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 2. Diet | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 3. Work | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 4. Active recreation *(e.g., sports)* | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 5. Passive recreation  *(e.g., reading, listening to music)* | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 6. Financial situation | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 7. Relationship with your spouse  *(girlfriend or boyfriend if not married)* | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 8. Sex life | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 9. Family relations | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 10. Other social relations | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 11. Self-expression/self-improvement | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 12. Religious expression | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |
| 13. Community and civic involvement | 1 | 2 | 3 | | 4 | 5 | | 6 | 7 |

*Office Use Only:* Enter

# ATHENS INSOMNIA SCALE

*This scale is intended to record your own assessment of any sleep difficulty you might have experienced. Please, check (by circling the appropriate number) the items below to indicate your estimate of any difficulty, provided that it occurred at least three times per week during the last month.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. SLEEP INDUCTION (time it takes you to fall asleep after turning-off the lights) | | | | | | |
| **0**  No problem | | **1**  Slightly delayed | | **2**  Markedly delayed | | **3**  Very delayed or did not sleep at all |
| 1. AWAKENINGS DURING THE NIGHT | | | | | | |
| **0**  No problem | | **1**  Minor problem | | **2**  Considerable problem | | **3**  Serious problem or did not sleep at all |
| 1. FINAL AWAKENING EARLIER THAN DESIRED | | | | | | |
| **0**  Not earlier | | **1**  A little earlier | | **2**  Markedly earlier | | **3**  Much earlier or did not sleep at all |
| 1. TOTAL SLEEP DURATION | | | | | | |
| **0**  Sufficient | | **1**  Slightly insufficient | | **2**  Markedly insufficient | | **3**  Very insufficient or did not sleep at all |
| 1. OVERALL QUALITY OF SLEEP (no matter how long you slept) | | | | | | |
| **0**  Satisfactory | **1**  Slightly unsatisfactory | | **2**  Markedly unsatisfactory | | **3**  Very unsatisfactory or did not sleep at all | |
| 1. SENSE OF WELL-BEING DURING THE DAY | | | | | | |
| **0**  Normal | | **1**  Slightly decreased | | **2**  Markedly decreased | | **3**  Very decreased |
| 1. FUNCTIONING (PHYSICAL AND MENTAL) DURING THE DAY | | | | | | |
| **0**  Normal | | **1**  Slightly decreased | | **2**  Markedly decreased | | **3**  Very decreased |
| 1. SLEEPINESS DURING THE DAY | | | | | | |
| **0**  None | | **1**  Mild | | **2**  Considerable | | **3**  Intense |

*Office Use Only:* Enter

# STOP-BANG Questionnaire

Please answer the following questions:

|  |  |
| --- | --- |
| 1. Do you **S**nore? | Choose |
| 1. Do you feel **T**ired, fatigued or sleepy during the day? | Choose |
| 1. Has anyone **O**bserved you stop breathing in your sleep? | Choose |
| 1. Do you have high blood **P**ressure? | Choose |

Height: Enter Weight: Enter Neck Size: Enter

**B**- BMI greater than 35? **BMI:** Enter

**A**- Age 50 years or older?

**N**- Neck circumference greater than 17 inches in MALE or 16 inches in FEMALE?

Gender: Choose STOP-BANG Score: Enter

**Height (inch/cm)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 4’10/147.3 | 5’0/152.4 | 5’2/157.5 | 5’4/162.6 | 5’6/167.6 | 5’8/172.7 | 5’10/177.8 | 6’0/182.9 | 6’2/188.0 |
| 135/61.4 | 28 | 26 | 25 | 23 | 22 | 21 | 19 | 18 | 17 |
| 140/63.6 | 29 | 27 | 26 | 24 | 23 | 21 | 20 | 19 | 18 |
| 145/65.9 | 30 | 28 | 27 | 25 | 23 | 22 | 21 | 20 | 19 |
| 150/68.2 | 31 | 29 | 27 | 26 | 24 | 23 | 22 | 20 | 19 |
| 155/70.5 | 32 | 30 | 28 | 27 | 25 | 24 | 22 | 21 | 19 |
| 160/72.3 | 34 | 31 | 29 | 28 | 26 | 24 | 23 | 22 | 21 |
| 165/75.0 | 35 | 32 | 30 | 28 | 27 | 25 | 24 | 22 | 21 |
| 170/77.3 | 36 | 33 | 31 | 29 | 28 | 26 | 24 | 23 | 22 |
| 175/79.6 | 37 | 34 | 32 | 30 | 28 | 27 | 25 | 24 | 23 |
| 180/81.2 | 38 | 35 | 33 | 31 | 29 | 27 | 26 | 25 | 23 |
| 185/84.1 | 39 | 36 | 34 | 32 | 30 | 28 | 27 | 25 | 24 |
| 190/86.4 | 40 | 37 | 35 | 33 | 31 | 29 | 27 | 26 | 24 |
| 195/88.6 | 41 | 38 | 36 | 34 | 32 | 30 | 28 | 27 | 25 |
| 200/90.9 | 42 | 39 | 37 | 34 | 32 | 30 | 29 | 27 | 26 |
| 205/93.2 | 43 | 40 | 38 | 35 | 33 | 31 | 29 | 28 | 26 |
| 210/95.5 | 44 | 41 | 38 | 36 | 34 | 32 | 30 | 29 | 27 |
| 215/97.7 | 45 | 42 | 39 | 37 | 35 | 33 | 31 | 29 | 28 |
| 220/100.0 | 46 | 43 | 40 | 38 | 36 | 34 | 32 | 30 | 28 |
| 225/102.3 | 47 | 44 | 41 | 39 | 36 | 34 | 32 | 31 | 29 |
| 230/104.6 | 48 | 45 | 42 | 40 | 37 | 35 | 33 | 31 | 30 |
| 235/106.8 | 49 | 46 | 43 | 40 | 38 | 36 | 34 | 32 | 30 |
| 240/109.1 | 50 | 47 | 44 | 41 | 39 | 37 | 34 | 33 | 31 |
| 245/111.4 | 51 | 48 | 45 | 42 | 40 | 37 | 35 | 33 | 32 |
| 250/113.6 | 52 | 49 | 46 | 43 | 40 | 38 | 36 | 34 | 32 |

**Weight (lbs/kgs)**

# IN YOUR LIFETIME

|  |  |
| --- | --- |
| 1. Have you ever had spells or anxiety attacks when all of sudden? You felt frightened, anxious, or very uneasy in situations when most people would not be afraid? | Choose |
| If “yes”, how old were you when you first had one of these spells of feeling frightened or anxious? | Age: Enter years |
| 1. Have you ever had a strong fear of something or some situation that you know is unreasonable, which other people are not afraid of and which you try to avoid even though there is no real danger? | Choose |
| If “yes”, how old were you when you first had this (these) fears? | Age: Enter years |
| 1. Have you ever had two weeks or more during which you felt sad, blue, depressed, or when you lost all your pleasure in things you usually care about or enjoy? | Choose |
| If “yes”, how old were you when you first had this period of being sad, depressed, etc.? | Age: Enter years |
| 1. Have you ever had a period of one week or more when you were so happy or excited or high that you got into trouble, or your friends and family were worried about you? | Choose |
| If “yes”, how old were you when you first had this period of being happy, excited, etc.? | Age: Enter years |
| 1. Have you ever been bothered by certain thoughts that kept running through your mind, over and over, so that you couldn’t get rid of them no matter how hard you tried, such as silly or unwanted or scary thoughts, or ideas that kept popping in your head, mostly against your will? | Choose |
| If “yes”, how old were you when you first had these types of thoughts? | Age: Enter years |
| 1. Have you ever felt forced to repeat certain actions over and over again even if did not make sense to you or others? S*uch as washing your hands over and over even though you know they are clean or checking the locks in the house even though you know you locked them before?* | Choose |
| If “yes”, how old were you when you first had these types of thoughts? | Age: Enter years |
| 1. Have you ever had the experience of seeing something or someone that others who were present could not see, that is, had a vision when you were completely awake? | Choose |
| 1. Have you ever had the experience of hearing things other people couldn’t hear, such as voices or other sounds? | Choose |
| 1. Have you ever been bothered by strange smells around you that nobody else seemed able to smell? | Choose |
| 1. Have you ever had unusual feelings inside or on your body? | Choose |
| 1. Has there ever been a period of two weeks or more when everyday you were drinking 7 or more beers, 7 or more drinks, or 7 more glasses of wine? | Choose |
| 1. Has your family or friends ever objected because you were drinking too much? | Choose |
| 1. Did you ever think you were an excessive drinker? | Choose |
| 1. Have you ever been told by a doctor, clergyman or other professional that you were drinking too much for your own good? | Choose |
| 1. Do you drink less alcohol now than you did in the past? | Choose |
| 1. Have you ever felt the need to cut down on your drinking? | Choose |
| 1. Do you get annoyed by others asking about your drinking? | Choose |
| 1. Have you ever needed to drink first thing in the morning? | Choose |
| 1. Do you use alcohol now to help you sleep at night? | Choose |
| 1. Have you ever had treatment for excessive drinking? | Choose |
| 1. Have you ever had treatment for excessive drug/medication use? | Choose |

# Rosenberg Scale

Please select the appropriate number

**1** = STRONGLY AGREE **2** = AGREE **3** = DISAGREE **4** = STRONGLY DISAGREE

|  |  |
| --- | --- |
| 1. I feel that I’m a person of worth, at least, on an equal basis with others | Choose |
| 1. I feel that I have a number of good qualities | Choose |
| 1. All in all, I am inclined to feel that I am a failure | Choose |
| 1. I am able to do things as well as most other people | Choose |
| 1. I feel I do not have much to be proud of | Choose |
| 1. I take a positive attitude towards myself | Choose |
| 1. On the whole, I am satisfied with myself | Choose |
| 1. I wish I could have more respect for myself | Choose |
| 1. I certainly feel useless at times | Choose |
| 1. At times I think I am no good at all | Choose |

*Office Use Only:* Enter

# ZOGIM-A

**This brief questionnaire deals with your level of alertness. Use the following scale to check one response for each question.**

|  |  |
| --- | --- |
| 1. How might your alertness be affected by each of the following? | |
| a. Losing about 30 minutes of night-time sleep. | Choose |
| b. Doing about 30 minutes of exercise. | Choose |
| c. Not drinking coffee or other foods that contain caffeine. | Choose |
| d. Taking a 1-week vacation. | Choose |
| e. Forgetting about your worries. | Choose |

|  |  |
| --- | --- |
| 2. If you were more alert: | |
| a. Would you be able to organize your day-to-day activities more effectively? | Choose |
| b. Would you be able to complete your tasks more methodically? | Choose |
| c. Would your new ideas occur to you more readily? | Choose |
| d. Would you make fewer careless mistakes? | Choose |

|  |  |
| --- | --- |
| 3. What proportion of the day do you feel a high level of alertness? | Choose |

*Office Use Only:* Enter

# Epworth Sleepiness Scale

**How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?**

*This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation*

0 = would **never** doze 1 = **slight** chance of dozing 2 = **moderate** chance of dozing 3 **= high** chance of dozing

|  |  |
| --- | --- |
| Situation | Chance of Dozing |
| Sitting and reading | Choose |
| Watching TV | Choose |
| Sitting, inactive in a public place (e.g. theatre or a meeting) | Choose |
| As a passenger in a car for an hour without a break | Choose |
| Lying down to rest in the afternoon when circumstances permit | Choose |
| Sitting and talking to someone | Choose |
| Sitting quietly after a lunch without alcohol | Choose |
| In a car, while stopped for a few minutes in the traffic | Choose |

*Office Use Only:* Enter

# Fatigue Severity Scale

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| During the past week, I have found that: | Completely Disagree | | Neither Agree  Nor Disagree | | | | | Completely Agree | |
| 1. My motivation is lower when I am fatigued. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 2. Exercise brings on my fatigue. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 3. I am easily fatigued. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 4. Fatigue interferes with my physical functioning. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 5. Fatigue causes frequent problems for me. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 6. My fatigue prevents sustained physical functioning. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 7. Fatigue interferes with carrying out certain  duties and responsibilities. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 8. Fatigue is among my three most disabling symptoms. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |
| 9. Fatigue interferes with my work, family, or social life. | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 |

*Office Use Only*

*Total:* Enter

*Average:* Enter

|  |  |
| --- | --- |
| Please choose appropriate answer | |
| Do you typically awaken with a dry mouth? | Choose |
| Do you typically awaken with a sore throat? | Choose |
| Do you drool on your pillow during the night? | Choose |
| Do you have problems with penile erections (i.e. impotence)? | Choose |
| Do you frequently awaken during the night to void urine? | Choose |
| Do you experience frequent heartburn or reflux during the night? | Choose |
| Do you wake up with headaches in the morning? | Choose |
| Did you ever have a fractured jaw, broken nose or oral problems? | Choose |
| Have you ever done heavy exercise or manual labor? | Choose |

|  |  |
| --- | --- |
|  | The grading of palatine tonsil hypertrophy was summarized as follows:  0 \_ no enlargement;  1 \_ tonsils occupy less than half of the transverse diameter of oropharynx;  2 \_ tonsils occupy half of the transverse diameter of oropharynx;  3 \_ tonsils occupy more than half of the transverse diameter of oropharynx;  4 \_ tonsils occupy whole of the transverse diameter of oropharynx, i.e., kissing tonsils. |

# TORONTO HOSPITAL ALERTNESS TEST (THAT)

*This questionnaire tries to establish how alert you feel. In reporting your feeling, we would like you to consider your last week. Use the following scale to check one response for each question.*

|  |  |
| --- | --- |
| During the last week, I felt: |  |
| 1. Able to concentrate | Choose |
| 1. Alert | Choose |
| 1. Fresh | Choose |
| 1. Energetic | Choose |
| 1. Able to think of new ideas | Choose |
| 1. Vision was clear noting all details (e.g. driving) | Choose |
| 1. Able to focus on the task at hand | Choose |
| 1. Mental facilities were operating at peak level | Choose |
| 1. Extra effort was needed to maintain alertness | Choose |
| 1. In a boring situation, I would find my mind wandering | Choose |

*Office Use Only:* Enter

# CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION

*Below is a list of the ways you might have felt or behaved. Please indicate how often you have felt this way* ***DURING THE PAST WEEK.***

**0** = Rarely or None of the Time (Less than l Day)

**1** = Some or a Little of the Time (1 - 2 Day)

**2** = Occasionally or a Moderate Amount of Time (3 - 4 Days)

**3** = Most or All of the Time (5 - 7 Days)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| During the past week: | | |  |  |  |
| 1. | I was bothered by things that usually don’t bother me | 0 | 1 | 2 | 3 |
| 2. | I did not feel like eating; my appetite was poor. | 0 | 1 | 2 | 3 |
| 3. | I felt that I could not shake off the blues even with help from my family or friends. | 0 | 1 | 2 | 3 |
| 4. | I felt that I was just as good as other people | 0 | 1 | 2 | 3 |
| 5. | I had trouble keeping my mind on what I was doing. | 0 | 1 | 2 | 3 |
| 6. | I felt depressed. | 0 | 1 | 2 | 3 |
| 7. | I felt that everything I did was an effort. | 0 | 1 | 2 | 3 |
| 8. | I felt hopeful about the future. | 0 | 1 | 2 | 3 |
| 9. | I thought my life had been a failure. | 0 | 1 | 2 | 3 |
| 10. | I felt fearful. | 0 | 1 | 2 | 3 |
| 11. | My sleep was restless. | 0 | 1 | 2 | 3 |
| 12. | I was happy. | 0 | 1 | 2 | 3 |
| 13. | I talked less than usual | 0 | 1 | 2 | 3 |
| 14. | I felt lonely. | 0 | 1 | 2 | 3 |
| 15. | People were unfriendly. | 0 | 1 | 2 | 3 |
| 16. | I enjoyed life | 0 | 1 | 2 | 3 |
| 17. | I had crying spells. | 0 | 1 | 2 | 3 |
| 18. | I felt sad. | 0 | 1 | 2 | 3 |
| 19. | I felt that people disliked me. | 0 | 1 | 2 | 3 |
| 20. | I could not get “going”. | 0 | 1 | 2 | 3 |

*Office Use Only:* 

# ZUNG ANXIETY

How often has each of the following statements applied to you during the past 2 weeks.

**1** = None or a little of the time **2** = Some of the time **3** = Good part of the time **4** = Most, or all, of the time

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. I feel more nervous and anxious than usual | 1 | 2 | 3 | 4 |
| 1. I feel afraid for no reason at all | 1 | 2 | 3 | 4 |
| 1. I get upset easily or feel panicky | 1 | 2 | 3 | 4 |
| 1. I feel like I’m falling apart and going to pieces | 1 | 2 | 3 | 4 |
| 1. I feel that everything is all right and nothing bad will happen | 1 | 2 | 3 | 4 |
| 1. My arms and legs shake and tremble | 1 | 2 | 3 | 4 |
| 1. I am bothered by headaches, neck and back pains | 1 | 2 | 3 | 4 |
| 1. I feel weak and get tired easily | 1 | 2 | 3 | 4 |
| 1. I feel calm and can sit still easily | 1 | 2 | 3 | 4 |
| 1. I can feel my heart beating fast | 1 | 2 | 3 | 4 |
| 1. I am bothered by dizzy spells | 1 | 2 | 3 | 4 |
| 1. I have fainting spells or feel like fainting | 1 | 2 | 3 | 4 |
| 1. I can breathe in and out easily | 1 | 2 | 3 | 4 |
| 1. I get feelings of numbness and tingling in my fingers and toes | 1 | 2 | 3 | 4 |
| 1. I am bothered by stomach aches or indigestion | 1 | 2 | 3 | 4 |
| 1. I have to empty my bladder often | 1 | 2 | 3 | 4 |
| 1. My hands are usually dry and warm | 1 | 2 | 3 | 4 |
| 1. My face gets hot and blushes | 1 | 2 | 3 | 4 |
| 1. I fall asleep easily and get a good night’s rest | 1 | 2 | 3 | 4 |
| 1. I have nightmares | 1 | 2 | 3 | 4 |

*Office Use Only:* 

# Sexual Health

Sleep problems and sexual difficulties can occur together and for this reason we ask some questions about your sexual functioning. Particular problems or concerns can be discussed in more detail, if you wish, during your appointment. The questions concern the time frame covering the last six months. Please select the appropriate answer.

|  |  |
| --- | --- |
| 1. Are you sexually active with a partner? | Choose |
| 1. Do some problems with your sleep interfere with your sex life? | Choose |
| 1. Do sexual experiences make your sleep worse? | Choose |
| 1. Do you find that you sleep better after sexual activity? | Choose |
| 1. Do you feel that you have a sexual problem or concern? | Choose |
| 1. Have you ever had periods of dramatic increase in sexual interest lasting   2-3 days, possibly in relation to changes in sleep? | Choose |
| 1. Approximately how many times per month do you have sexual intercourse? | Choose |

## Female Sexual Health

### (for women only)

|  |  |
| --- | --- |
| 1. Have you ever used a birth control pill? | Choose |
| 1. Are you past the change of life (menopause)? | Choose |
| 1. Are you having any symptoms of the menopause now? | Choose |
| 1. Does/did the pattern of your sleep change around the time of your period? | Choose |
| 1. Do/did you experience premenstrual symptoms with your periods? | Choose |
| 1. Do you usually have a problem coming to orgasm? | Choose |

## Male Sexual Health

### (for men only)

|  |  |
| --- | --- |
| 1. Do you have any difficulties getting an erection? | Choose |
| 1. Do you have difficulties maintaining an erection? | Choose |
| 1. Do you get painful erections during the night? | Choose |
| 1. Do you have any other sexual concerns that have not been asked about? | Choose |
| 1. How often do you awaken with an erection during the night or morning? | Choose |

# RLS Questionnaire

*Please, answer the following questions according to your best knowledge! Where you can choose between* ***Yes*** *or* ***No****, choose the appropriate.*

|  |  |
| --- | --- |
| 1. Does it happen or did it happen earlier that you experienced recurrent unpleasant sensation or tingling in your legs, while sitting or laying down? | Choose |
| If **Yes,** how would you describe this sensation? | Choose |
| 1. Does it happen or did it happen earlier that you repeatedly felt an urge “to move” your legs while sitting or laying down? | Choose |
| If **Yes**, do you need move your whole body not only your legs? | Choose |
| This feeling, that you have to move, is sometimes so pressing that you can not resist it? | Choose |
| Or you just simply have to move your arms or legs? | Choose |
| 1. Do your legs jump or move involuntarily while sitting or laying down? | Choose |
| If **Yes**, do you think that the sensations in your legs and the movements are connected? | Choose |
| If **Yes**, how often do these involuntary movements occur | Choose |
| Do these involuntary movements occur only before you fall asleep? | Choose |
| 1. Do you feel, or did you feel earlier that there are recurrent periods when you are so itchy, you cannot stay in one place or you have to move your arms or legs? | Choose |
| *Continue to answer the following questions* ***ONLY*** *if you answered* ***YES*** *to at least one of the previous questions.*  *If you answered* ***no*** *to all of the above questions, please go to the next page****.*** | |
| 1. When these sensations or movements occur, are they worse while you have a rest (while sitting or lying down) than during physical activities? | Choose |
| 1. If these sensations or movements are present and you get up to walk, do they improve or do they disappear while you are walking? Please, try to remember, that you may have observed that these sensations or movements get worse again when you stop walking, but they are less cumbersome while you are walking? | Choose |
| *Continue to answer the following questions* ***ONLY*** *if you answered* ***YES*** *to both of the last two questions.*  *If you answered no to question 5 or 6, please go to the next page.* | |
| 1. If these sensations or movements are present do they get worse in the evening or during the night? | Choose |
| 1. Not NOW, but when you first had these sensations or movements (even if they were not as bad as they are now) were these sensations or movements worse in the evening or during the night? | Choose |

# PARASOMNIA

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you talk in your sleep? | | | Choose | |
| Do you grind or clench your teeth while asleep? | | | Choose | |
| Do you sleepwalk? | | | Choose | |
| Do you experience episodes of extreme terror or screaming, during sleep, yet have little if any recall of the event? | | | Choose | |
| While asleep, have you ever acted out a dream and injured yourself or a bed partner? | | | Choose | |
| Do you have frequent nightmares? | | | Choose | |
| Do you eat in your sleep? (This is not concerning dreams) | | | Choose | |
| Have you ever initiated sexual activity with a bed partner while asleep? | | | Choose | |
| Has your partner ever initiated sexual activity with you while he/she was asleep? | | | Choose | |
| Have you had any unusual behavior in sleep? | | | Choose | |
| If so, please elaborate | | | Enter | |
| If you have any of the above parasomnia, do you find they are triggered by (*tick all of those that you believe could be a factor in a parasomnia*) | ☐a. Heavy exercise  ☐b. Fever  ☐c. Alcohol  ☐d. External noise  ☐e. Sleep deprivation | ☐f. Intercourse  ☐g. Stress  ☐h. Apnea  ☐i. Sleeping in unfamiliar place | | ☐j. Physical contact  ☐k. Sleeping pills  ☐l. Anti-depressant  ☐m. Proximity to another person |
| Please rate the top three factors (*e.g.* k, c, e) | | | Enter | |
|  | | |  | |
| Do you experience sudden jerky body movements at sleep onset, causing an inability to initiate sleep? | | | Choose | |
| Have you ever woken up in the morning having bitten your tongue or cheek? | | | Choose | |
| Have you had any episodes of urinary incontinence during sleep? | | | Choose | |

*If you could choose between the following, which would be your first, second, and third choice?*

a) 5 hrs of deep refreshing sleep Enter

b) 6 hrs of light sleep Enter

c) 7 hrs of broken sleep Enter

|  |  |
| --- | --- |
| What time do you usually go to bed? | Enter |
| What time do you usually get up? | Enter |
| How many times per night do you typically awaken? | Enter |
| How long does it typically take you to fall asleep | Enter minutes |
| Approximately, how many hours of sleep do you get most nights? | Enter |
| How many hours of sleep would you like to get each night? | Enter |
| Typically, how many naps do you take per week? | Enter |
| Typically, how long are you naps? | Enter minutes |
| Are your naps refreshing for you? | Enter |
| Do you dream during your naps? | Choose |

|  |  |
| --- | --- |
| Do you work night shifts? | Choose |
| Do you work changing shifts? | Choose |
| Do you travel across time zones differing by more than two hours more than once per month? | Choose |

|  |  |
| --- | --- |
| How many motor vehicle collisions have you been involved in over the past 5 years (*include accidents even if not at fault*)? | Enter |
| How many work related injuries have occurred to you in the past 5 years? | Enter |
| Have you ever been involved in an accident or injured yourself because you fell asleep? | Choose |
| How many days of work (or school) have you missed over the past year (*not including vacations*)? | Enter |

# FAMILY HISTORY

*Please check (√) in the proper space if one of the following applies to a member of your family (current or past).*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Son | | Daughter | | Brother | | Sister | | Father | Mother | Spouse | Other (specify) |
| Sleep Walking | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Screaming During Sleep | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Loud Snoring in Sleep | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep Apnea | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Daytime Sleepiness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Insomnia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chronic Fatigue | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Death During Sleep | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Restless Legs | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Parkinson’s Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cardiovascular Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Other:* Enter

# THE OWL LARK SELF-TEST

With these last 19 questions do your best. Select one answer that makes the most sense to you.

1. Considering only your own “feeling best” rhythm, at what time would you get up if you were

entirely free to plan your day? (Choose time period by selecting 5, 4, 3, 2 or 1)

5 4 3 2 1

5 am 6am 7 am 8 am 9 am 10 am 11 am noon

1. Considering only your own “feeling best” rhythm, at what time would you go to bed if you

were entirely free to plan your evening (Choose time period by selecting 5, 4, 3, 2 or 1)

****5 ****4 **** 3 ****2 ****1

8pm 9 pm 10 pm 11 pm 12 am 1am 2 am 3am

|  |  |
| --- | --- |
| 1. If there is a specific time at which you have to get up in the morning, to what extent are you dependent on being woken up by an alarm clock?   Not at all dependent ☐4  Slightly dependent ☐ 3  Fairly dependent ☐ 2  Very dependent ☐ 1 | 7. During the first half hour after having woken in the morning, how tired do you feel?  Very tired ☐ 1  Fairly tired ☐ 2  Fairly refreshed ☐ 3  Very refreshed ☐ 4 |
| 1. Assuming adequate environmental conditions, how easy do you find getting up in the morning?   Not at all easy ☐ 1  Not very easy ☐ 2  Fairly easy ☐ 3  Very easy ☐ 4 | 8. When you have no commitments the next day, at what time do you go to bed compared to your usual bedtime?  Seldom or never later ☐ 4  Less than one hour later ☐ 3  1-2 hours later ☐ 2  More than two hours later ☐ 1 |
| 1. How alert do you feel during the first half hour after having woken in the mornings?   Not at all alert ☐ 1  Slightly alert ☐ 2  Fairly alert ☐ 3  Very alert ☐ 4 | 9. You have decided to engage in some physical exercise. A friend suggests that you do this one hour twice a week and the best time for him is between 7:00 – 8:00 am. Bearing in mind nothing else but you own “feeling best” rhythm, how do you think you would perform?  Would you be in good form ☐ 4  Would be in reasonable form ☐ 3  Would find it difficult ☐ 2  Would find it very difficult ☐ 1 |
| 1. How is your appetite during the first half hour after having woken in the mornings?   Very poor ☐ 1  Fairly poor ☐ 2  Fairly good ☐ 3  Very good ☐ 4 |

10. At what time in the evening do you feel tired and as a result in need of sleep?

5 4 3 2 1

8 pm 9 pm 10 pm 11 pm 12 am 1 am 2 am 3am

|  |  |
| --- | --- |
| 11. You wish to be at your peak performance for a test which you know is going to be mentally exhausting and lasting for two hours. You are entirely free to plan your day and considering only your own “feeling best” rhythm, which ONE of the four testing times would you choose?  8:00 – 10:00 am ☐6  11:00 am –1:00 pm ☐ 4  3:00 pm – 5:00 pm ☐ 2  7:00 – 9:00 pm ☐ 0 | 14. One night you have to remain awake between 4– 6:00 am in order to carry out a night watch. You have no commitments the next day. Which ONE of the following alternatives will suit you best?  ☐ 1 Would NOT go to bed until watch was over  ☐ 2 Would take a nap before and sleep after  ☐ 3 Would take a good sleep before and nap after  ☐ 4 Would take ALL sleep before watch |
| 12. If you went to bed at 11:00 pm, at what level  of tiredness would you be?  Not at all tired ☐ 0  A little tired ☐ 2  Fairly tired ☐ 3  Very tired ☐ 5  13. For some reason you have gone to bed several hours later than usual, but there is no need to get up at any particular time the next morning. Which ONE of the following events are you most likely to experience?  ☐ 4 Will wake up at usual time and will NOT fall  asleep again  ☐ 3 Will wake up at usual time and will dose  thereafter  ☐ 2 Will wake up at usual time but will fall sleep  again  ☐ 1 Will NOT wake up until later than usual | 15. You have to do two hours of hard physical work. You are entirely free to plan your day and consider only your own “feeling best” rhythm, which ONE of the following times would you choose?  8:00 am – 10:00 am ☐ 4  11:00 am – 1:00 pm ☐ 3  3:00 pm – 5:00 pm ☐ 2  7:00 pm – 9:00 pm ☐ 1 |
| 16. You have decided to engage in hard physical exercise. A friend suggests that you do this for one hour twice a week and the best time for him is between 10:00 – 11:00 pm. Bearing in mind nothing else but your own “feeling best” rhythm, how well do you think you would perform?  Would you be in good form ☐ 1  Would be in reasonable form ☐ 2  Would find it difficult ☐ 3  Would find it very difficult ☐ 4 |

17. Suppose that you can choose your own work hours. Assume that you worked a FIVE-hour day (with breaks) and that your job was interesting and paid by results. Which five consecutive hours would you select?

1 5 4 3 2 1

12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12

Midnight Noon Midnight

18. At what time of the day do you think that you reach your “feeling best” peak?

1 5 4 3 2 1

12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12

Midnight Noon Midnight

19. One hears about “morning” and “evening” types of people. Which ONE of these types do you consider yourself to be?

Definitely a “morning” type? ☐6

Rather more than a “morning” than an “evening” type ☐4

Rather more an “evening” than a “morning” type ☐2

Definitely an “evening” type ☐0

# TREATMENT OF YOUR SLEEP PROBLEM

**For your sleeping problems, have you tried or had**

*(Please select those that you have tried)*

**0** = Not at all **1** = Little **2** = Moderately **3** = Great deal

|  |  |
| --- | --- |
| 1. Relaxation training | Choose |
| 1. Relaxation tapes | Choose |
| 1. Biofeedback | Choose |
| 1. Cognitive re-focusing | Choose |
| 1. Self-hypnosis | Choose |
| 1. Surgery | Choose |
| 1. Machines or prosthetic devices to help you breathe better while sleeping | Choose |
| 1. Group treatment | Choose |
| 1. Bed restriction | Choose |
| 1. Other (*state*): Enter | Choose |

# YOUR SLEEP ENVIRONMENT

|  |  |
| --- | --- |
| It is important that we know some things about your current sleeping environment and sleep habits.  (*Please select the appropriate answer*) | |
| 1. **I**s your bedroom separate (with its own door) from other living areas in the house? | Choose |
| 1. **W**hen you enter your bedroom at night, do you usually feel relaxed? | Choose |
| 1. **C**an your bedroom be made completely dark? | Choose |
| 1. **C**an your bedroom be made completely quiet? | Choose |
| 1. **D**o you use a special surface (bed board, orthopedic mattress, water bed, etc.)? | Choose |
| 1. **D**o you have a tv, radio or stereo in your bedroom? | Choose |
| 1. **D**o you use your bedroom for any activity other than sleep and intimacy? | Choose |

# FOR OFFICE USE ONLY

|  |  |
| --- | --- |
| Identification | Enter |
| Chief Complaints | Enter |
| History of Present Illness | Enter |
| Past Medical History  (*including Psychiatric*) | Enter |
| Note: Allergies | Enter |
| Family History | Enter |
| Educational History | Enter |
| Social History | Enter |

|  |  |
| --- | --- |
| Current Medications with Dosages | Enter |
| Over the counter medications: | Enter |
| Sleep Concern | Enter |
| Cognitive Function | Enter |
| Mental State: See Opposite Page | Enter |
| Impressions | Enter |
| Plan (sleep wise) | Enter |

# FOR OFFICE USE ONLY

|  |  |
| --- | --- |
| Mental status examination | |
| Age/appearance | **Appeared**: ☐stated age / ☐ older/ younger / ☐ thin / ☐ average /  ☐ overweight |
| Level of consciousness | ☐ Alert / ☐ oriented / ☐ confused / ☐ delirious |
| Appearance | ☐ Dressed appropriately / ☐ unkempt / ☐ overdressed / ☐ pale / ☐ marks /  ☐ scars / ☐ obese |
| Behavior  Normal | ☐ Cooperative / ☐ abnormal movements / ☐ posture: anxious / ☐ fidgety /  ☐ Tapping of feet / ☐ eye contact / ☐ posture |
| Speech & language  ☐ Normal / ☐ Spontaneously | **Rate**: ☐ normal / ☐ hesitant poverty of speech / ☐ pressure / ☐ echolalia /  ☐ perseveration of speech  **Rhythm**: ☐ normal / ☐ stuttering / ☐ dysarthria / ☐ word finding problems  **Volume**: ☐ normal / ☐ soft / ☐ loud / ☐ whisper |
| Affect  ☐ Appropriate | ☐ Inappropriate / ☐ blunted / ☐ restricted / ☐ flat / ☐ labile /  ☐ sad / ☐ happy |
| Mood  ☐ Normal | ☐ Euthymic / ☐ low / ☐ labile/ ☐ euphoric / ☐ expansive/ ☐ dysphoric /  ☐ anhedonia / ☐ tearful |
| Suicidal  ☐ Not | ☐ Plan / ☐ ideations / ☐ attempt |
| Thought form  ☐ Normal | ☐ Flight of ideas / ☐ looseness of association / ☐ circumstantiality /  ☐ tangentiality / ☐ clang association / ☐ thought blocking /  ☐ insertion and withdrawal / ☐ word  ☐ Salad / ☐ incoherent |
| Thought content ☐ Normal | **Delusions**: ☐ grandiosity / ☐ persecutory / ☐ erotomamic / ☐ nihilistic /  ☐ somatic / ☐ delusions of reference / ☐ delusions of control / ☐ infidelity /  ☐ mood congruent / ☐ incongruent / ☐ hypochondriac  ☐ Fear / ☐ phobias / ☐ obsessions |
| Perceptual disorders  ☐ None | **Hallucinations**: ☐ auditory / ☐ visual / ☐ tactile / ☐ somatic /  ☐ olfactory illusions / ☐ diplopia / ☐ agnosia |
| Memory | ☐ Recent / ☐ remote  **7 part name + address**: immediate Enter /  after 5 minutes Enter |
| Concentration | **Serial 7’s time** Enter  **Sequence**: Enter |
| Intelligence  ☐ Normal | ☐ Mental retardation / ☐ dementia / ☐ abstract thinking: *e.g. Rolling stone* |
| Insight  ☐ Normal | ☐ Present / ☐ partial / ☐ impaired / ☐ absent |
| Judgment  ☐ Normal | ☐ Formal (e.g. Stamped envelope) / ☐ informal |
| Academic skills | ☐ Alteration in reading, writing, frequent letter or number reversal,  Calculating and number abilities |
| Motor ☐ Normal | ☐ Weakness or clumsiness / ☐ impaired fine motor coordination / ☐ apraxias |
| Visuospatial abilities  ☐ Normal | ☐ Diminished ability to perform manual skills / ☐ left-right disorientation /  ☐ Impaired spatial judgment |

1. *Please Enable Editing and Enable Content of the document.* [↑](#footnote-ref-1)