Sleep Diagnostic & Treatment Center

Experienced. Caring. Sleep Solutions.

AMERICAN ACADEMY OF SLEEP MEDICINE WAKE SLEEP ACCREDITED MEMBER CENTER

Sleep Health Questionnaire

Name: _____ D.O.B.: _____ Date: _____

Present Height: _____ft _____in Present Weight: _____lbs

Please state in your own words the reason for a sleep evaluation.

_____

Have you had previous sleep evaluation? If so, when and what were the results?

_____

Please check any of the following that may affect your sleep

___ Snoring
___ Choking sensation
___ Shortness of breath
___ Morning dry mouth
___ Morning headache
___ Heart racing
___ Chest pain
___ Sweating at night

___ Difficulty falling asleep
___ Many awakenings
___ Worried about not sleeping
___ Anxiety/racing thoughts
___ Waking up before alarm
___ Sleep better when away from home

___ Urge to move legs
___ Relief with movement
___ Creepy crawley feeling
___ Leg/foot cramps
___ Pain or discomfort
___ Muscle tension
___ Symptoms worse at night

___ Nightmares/ bad dreams
___ Wake up in a panic
___ Wake up screaming
___ Wake up with violence
___ Wake up confused
___ Acting out in dreams
___ Sleep walking
___ Sleep talking
___ Eating at night
___ Wet the bed
___ Shaking/convulsive movements
___ Tongue biting

___ Feeling unable to move
___ Daytime sleep attacks
___ Sounds/images when falling asleep or waking up

___ Does your body become weak or limp with strong emotions

___ Noise
___ Caring for Children
___ Room temperature
___ Other (please describe): _____
___ Bed partner/moving

Have you had a motor vehicle crash (or near-miss) due to daytime sleepiness? If so, how often and/or when did it occur?

_____

_____

_____

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Name: _____ D.O.B.: _____ Date: _____

How much weight have you gained or lost in the past 1 year?
_____lbs

How often do you exercise? _____ times/week

What time of day? _____

Activities you do in the bedroom

How long per day and night?

Watch TV _____
Use a computer _____
Use a phone or tablet _____
Read _____
Work or study _____
Eat _____

Sleep Schedule

What time do you go to bed? _____
Do you take any sleep aids? _____
How long does it take you to fall asleep? _____
How many times do you wake up during the night? _____
What time do you wake up in the mornings? _____
How often do you take naps? _____
What are your work hours? _____
What days do you work? _____

Habits

How long per day and night?

Do you drink caffeinated coffee? _____
Do you drink caffeinated tea? _____
Do you drink caffeinated soda? _____
What time is your last drink? _____
Do you drink wine? _____
Do you drink beer? _____
Do you drink mixed drinks? _____
What time is your last drink? _____
Do you smoke cigarettes? _____
Do you smoke cigars? Do you chew tobacco? _____
What time is your last tobacco use? _____
How long have you use tobacco? _____

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Name: _____ D.O.B.: _____ Date: _____

Do you have a history of non-prescription drug use? If so, please list what you have used:

_____

_____

Likelihood of falling asleep **0 = would never doze off**	**0** **1 = slight chance**	**1** **2 = moderate chance**	**2** **3 = high chance**	**3**
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting quietly in a public place (i.e. theatre or meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when able to	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes	○	○	○	○

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Name: _____ D.O.B.: _____ Date: _____

Feelings Survey

1.
- I do not feel sad.
- I feel sad much of the time.
- I am sad all of the time.
- I am so sad or unhappy that I cannot stand it.

2.
- I am not discouraged about my future.
- I feel more discouraged about my future than I used to be.
- I do not expect things to work out for me.
- I feel my future is hopeless and will only get worse.

3.
- I do not feel like a failure.
- I have failed more than I should have.
- As I look back, I see a lot of failures.
- I feel I am a total failure as a person.

4.
- I get as much pleasure as I ever did from the things I enjoy.
- I don't enjoy things as much as I used to.
- I get very little pleasure from the things I used to enjoy.
- I can't get any pleasure from the things I used to enjoy.

5.
- I don't feel particularly guilty.
- I feel guilty over many things I have done or should have done.
- I feel quite guilty most of the time.
- I feel guilty all of the time.

6.
- I don't feel I am being punished.
- I feel I may be punished.
- I expect to be punished.
- I feel I am being punished.

7.
- I feel the same about myself as ever.
- I have lost confidence in myself.
- I am disappointed in myself.
- I dislike myself.

8.
- I don't criticize or blame myself more than usual.
- I am more critical of myself than I used to be.
- I criticize myself for all of my faults.

9.
- I don't have any thoughts of killing myself.
- I have thoughts of killing myself, but I would not carry them out.
- I would like to kill myself.
- I would kill myself if I had the chance.

10.
- I don't cry anymore than I used to.
- I cry more than I used to.
- I cry over every little thing.
- I feel like crying, but I can't.

11.
- I am no more restless or wound up than usual.
- I feel more restless or wound up than usual.
- I am so restless or agitated that I have to keep moving or doing something.

12.
- I have not lost interest in other people or activities.
- I am less interested in other people or things than before.
- I have lost most of my interest in other people or things.
- It's hard to get interested in anything.

13.
- I make decisions about as well as ever.
- I find it more difficult to make decisions than usual.
- I have much greater difficulty in making decisions than I used to.
- I have trouble making decisions.

14.
- I do not feel I am worthless.
- I don't consider myself as worthwhile and useful as I used to.
- I feel more worthless as compared to other people.
- I feel utterly useless.

15.
- I have as much energy as ever.
- I have less energy than I used to have.
- I don't have enough energy to do very much.
- I don't have enough energy to do anything.

16.
- I have not experienced any change in my sleeping pattern.
- I sleep somewhat more than usual.
- I sleep somewhat less than usual.
- I sleep a lot more than usual.
- I sleep a lot less than usual.
- I sleep most of the day.
- I wake up 1-2 hours early and can't get back to sleep.

17.
- I am no more irritable than usual.
- I am more irritable than usual.
- I am much more irritable than usual.
- I am irritable all the time.

18.
- I have not experienced any change in my appetite.
- My appetite is somewhat less than usual.
- My appetite is somewhat greater than usual.
- My appetite is much less than usual.
- My appetite is much greater than usual.
- I have no appetite at all.
- I crave food all the time.

19.
- I can concentrate as well as ever.
- I can't concentrate as well as usual.
- It's very hard to keep my mind on anything for very long.
- I find I can't concentrate on anything.

20.
- I am no more tired or fatigued than usual.
- I get more tired of fatigued more easily than usual.
- I am too tired or fatigued more easily than usual.
- I am too tired or fatigued to do most of the things I used to.

21.
- I have not noticed any recent change in my interest in sex.
- I am less interested in sex than I used to be.
- I am much less interested in sex now.
- I have lost interest in sex completely.