Patient Initials:_____Provider signature:_____Date:_____

Health and Sleep History Questionnaire

Name_____

Age_____ Race/Ethnicity_____Date_____

Name of Primary Physician: _____

Name of Referring Physician (*if not your primary physician*): _____

Briefly describe the problem(s) you are experiencing with your sleep or the reason you were referred to our sleep center.

_____

_____

_____

When did you first notice your sleep problem? What may have contributed to the onset of your difficulty sleeping (i.e. birth of a child, death of a loved one, traumatic event)? _____

_____

_____

What do you feel are the major contributors to your sleep problem at this time? _____

_____

_____

What medications and other treatments have you tried for your sleep problem to date?_____

_____

_____

What medication(s) are you currently taking for sleep? And how many times per week?_____

_____

How long (on average) does it take you to get to sleep? _____

How many times do you wake up in an average night? _____

How long on average do you remain awake during these awakenings (in total)? _____

How much sleep do you get in total in an average night? _____hours/night

How much sleep do you feel you need each night to feel well rested and able to function? _____hours/night

Does a poor night's sleep make you:

	Yes	No
Depressed	☐	☐
Anxious	☐	☐
Irritable	☐	☐
Fatigued	☐	☐

Does a poor night's sleep negatively affect your:

	Yes	No
Ability to concentrate	☐	☐
Memory	☐	☐
Ability to work	☐	☐
Mood	☐	☐

Other (please describe):_____

Patient Initials:_____ Provider signature:_____ Date:_____

Psychosocial History:

In what city/county do you live?_____

Who do you live with?_____

Status: ☐ Never Married ☐ Currently Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Is your current relationship satisfactory(circle)? **Yes or No or Not applicable**
If **No**, please explain:_____

_____

How many total years of education have you completed?_____

What college degree(s)/certificates have you earned? _____

_____

Where do you work and what is your profession? _____

_____

How long have you worked there? _____Years _____Months

Are you satisfied with your job? **Yes or No** If **No**, please explain_____

_____

Do you have children? **Yes or No** If yes, how many?_____

Are you experiencing any problems/conflicts related to your children? **Yes or No**
If yes, please explain_____

_____

Are you experiencing any family related conflicts or problems? **Yes or No** If yes, please explain:_____

_____

How is your social life (circle)? **Excellent Good Fair Limited Poor**

How is your activity level (circle)? **Excellent Good Fair Limited Poor**

Have you ever smoked? YES ☐ NO ☐ How Long? __Years How Much? __Packs/day When quit?_____

Do you drink alcohol of any kind? YES ☐ NO ☐ How many times per week?_____ How many drinks? _____

Do you drink caffeinated beverages? YES ☐ NO ☐ How many times per week?_____ How many drinks? _____

Have you ever used marijuana, cocaine, or other illicit drugs? YES ☐ NO ☐
If **YES**, which drug and how often? _____

Patient Initials:_____ Provider signature:_____ Date:_____

Medical History

Surgery	Surgeries: YES	NO	When?
Tonsillectomy	☐	☐	_____
Hernia	☐	☐	_____
Cardiac Bypass	☐	☐	_____
Hysterectomy	☐	☐	_____
Appendectomy	☐	☐	_____
Nasal Surgery	☐	☐	_____

Other:_____

_____

_____

_____

_____

Have you ever experienced a head injury?

☐ Yes ☐ No

If yes, when?_____

Condition	YES	NO	When Diagnosed?
Allergies/Asthma	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Cardiovascular Disease	☐	☐	_____
Diabetes	☐	☐	_____
Digestive Problems	☐	☐	_____
Hypertension	☐	☐	_____
Kidney Problems	☐	☐	_____
Liver Problems	☐	☐	_____
Respiratory Problems	☐	☐	_____
Thyroid Disorder	☐	☐	_____
Seizure Disorder	☐	☐	_____
Pain Condition**	☐	☐	_____

** Rate the severity of your pain, on a scale from 0-10, with 10 indicating the most severe pain you can imagine. _____.

Other:_____

_____

_____

Prescription Medications	Dosage	Taken For	How Long?
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			

Over the counter medications _____

_____

_____

Patient Initials:_____Provider signature:_____Date:_____

Psychiatric History

Are you currently being treated for a psychiatric disorder? YES ☐ NO ☐

If **YES**, who are your current providers and what is the focus of treatment?_____

_____

_____

_____

Have you ever been diagnosed or treated for a psychiatric disorder? YES ☐ NO ☐

If **YES**, when and what was your diagnosis and treatment outcome _____

_____

_____

Do you have a family history of…(please circle all that apply) **Depression Anxiety Bi-Polar D/O Psychosis Other:**_____

How would you rate your current level of sadness or depression on a scale from 0-10, with 0 indicating no depression to 10 indicating very severe depression? _____

To what would you attribute this sadness/depression or what do you feel is causing this level of depression?_____

_____

How would you rate your current level of stress or anxiety on a scale from 0-10, with 0 indicating no anxiety to 10 indicating very severe anxiety? _____

To what would you attribute this stress/anxiety, or what do you feel is causing this level of anxiety ?_____

_____

	YES	NO
Have you ever been hospitalized for psychiatric reasons?	☐	☐

If Yes, where and for how long?_____

_____

Are you currently prescribed psychiatric medications (i.e. antidepressants, anti-anxiety, mood stabilizers etc.)?	☐	☐
Have you ever been physically, emotionally, or sexually abused?	☐	☐
Have you ever felt so bad that you wanted to die or considered taking your own life?	☐	☐

Patient Initials:_____ Provider signature:_____ Date:_____

Sleep Symptoms:

	YES	NO
Has anyone told you that you snore loudly?	☐	☐
Has your family told you that you quit breathing at night?	☐	☐
Have you ever awakened gasping for breath?	☐	☐
Have you ever awakened at night with a sour taste in your mouth, or a burning sensation in your chest?	☐	☐
Do you have morning headaches?	☐	☐
Are you sleepy even when you increase your sleep time?	☐	☐

	YES	NO
Do you have trouble getting to sleep at night?	☐	☐
Do you have trouble staying asleep at night?	☐	☐
Do you have frequent awakenings and/or restless sleep?	☐	☐

	YES	NO
Do you frequently kick and jerk your legs at night while trying to fall asleep?	☐	☐
Do you have discomfort in your legs while trying to fall asleep?	☐	☐
If YES to previous question, does moving your legs give you relief of discomfort?	☐	☐
Do you have tingling or discomfort in your legs during the day?	☐	☐
Do you have discomfort in your legs when sitting for long periods?	☐	☐

	YES	NO
Do you have sudden episodes of sleep during the day?	☐	☐
Have you ever experienced periods in which you feel paralyzed while going to sleep, or waking up?	☐	☐
Have you ever had visual hallucinations or dream-like mental images when falling to sleep?	☐	☐
Have you ever experienced sudden physical weakness during strong emotions? (such as your mouth dropping open or legs going limp, during laughter or anger)	☐	☐
Were you excessively sleepy as a teenager or young adult?	☐	☐

	YES	NO
Do you sleep walk?	☐	☐
Do you talk in your sleep?	☐	☐
Do you have frequent nightmares?	☐	☐
Do you ever wake up screaming at night?	☐	☐
Do you eat in the middle of the night?	☐	☐
Do you physically act out your dreams at night?	☐	☐

	YES	NO
Do you grind your teeth in your sleep?	☐	☐
Have you or your dentist noticed your teeth being worn down?	☐	☐
Have you noticed that your teeth hurt?	☐	☐
Do you experience pain in your jaw muscles?	☐	☐
Has anyone told you that you make sounds with your teeth or jaw during sleep?	☐	☐

Patient Initials:_____ Provider signature:_____ Date:_____

	YES	NO
Do you have rotating or night shift work?	☐	☐
Have you ever worked shift work or had an on-call schedule?	☐	☐
Do you have difficulty getting to sleep at your desired time?	☐	☐
Do you wake up in the morning prior to your desired time?	☐	☐
Do you find that your present sleep schedule is inconvenient, inappropriate, or unsatisfactory?	☐	☐

Sleep Schedule

	Weekday	Weekend
Time you go to bed	_____	_____
Time you get up	_____	_____
Average amount of sleep per night	_____	_____

The Insomnia Severity Index

Name:_____ Date:_____

1. Please rate the current (i.e., last 2 weeks) severity of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very
a. Difficulty falling asleep:	0	1	2	3	4
b. Difficulty staying asleep:	0	1	2	3	4
c. Problem waking up too early:	0	1	2	3	4

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

Very Satisfied	Satisfied	Neutral	Dissatisfied	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 fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.).

Not at all Interfering	A little	Somewhat	Much	Very Much Interfering
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 Noticeable	A little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

5. How worried/distressed are you about your current sleep problem?

Not at all Worried	A little	Somewhat	Much	Very Much Worried
0	1	2	3	4

Morningness/Eveningness

Directions: For each item, please **check one** response that best describes you.

1. *Approximately what time would you get up if you were entirely free to plan your day?*
   - _____ 5:00-6:30am (5)
   - _____ 6:30-7:45am (4)
   - _____ 7:45-9:45am (3)
   - _____ 9:45-11:00am (2)
   - _____ 11:00am-12:00 noon (1)
2. *Approximately what time would you go to bed if you were entirely free to plan your evening?*
   - _____ 8:00-9:00pm (5)
   - _____ 9:00-10:15pm (4)
   - _____ 10:15pm-12:30am (3)
   - _____ 12:30-1:45am (2)
   - _____ 1:45am-3:00am (1)
3. *If you usually have to get up at a specific time in the morning, how much do you depend on an alarm clock?*
   - _____ Not at all (4)
   - _____ Slightly (3)
   - _____ Somewhat (2)
   - _____ Very much (1)
4. *How easy do you find it to get up in the morning (when you are not awakened unexpectedly)?*
   - _____ Very Difficult (1)
   - _____ Somewhat difficult (2)
   - _____ Fairly easy (3)
   - _____ Very easy (4)
5. *How alert do you feel during the first half hour after you wake up in the morning?*
   - _____ Not at all alert (1)
   - _____ Slightly alert (2)
   - _____ Fairly alert (3)
   - _____ Very alert (4)
6. *How hungry do you feel during the first half hour after you wake up?*
   - _____ Not at all hungry (1)
   - _____ Slightly hungry (2)
   - _____ Fairly hungry (3)
   - _____ Very hungry (4)
7. *During the first half hour after you wake up in the morning, how do you feel?*
   - _____ Very tired (1)
   - _____ Fairly tired (2)
   - _____ Fairly refreshed (3)
   - _____ Very refreshed (4)

8. *If you have no commitments the next day, what time would you go to bed compared to your usual bedtime?*

_____ Seldom or never later (4)
_____ Less than 1 hour later (3)
_____ 1-2 hours later (2)
_____ More than 2 hours later (1)

9. *You have decided to do physical exercise. A friend suggests that you do this for one hour twice a week, and the best time for him is between 7:00-8:00am. Bearing in mind nothing but your own internal "clock", how do you think you would perform?*

_____Would be in good form (4)
_____Would be in reasonable form (3)
_____Would find it difficult (2)
_____Would find it very difficult (1)

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

_____8:00-9:00pm (5)
_____9:00-10:15pm (4)
_____10:15pm-12:30am (3)
_____12:30-1:45am (2)
_____1:45-3:00am (1)

11. *You want to be at your peak performance for a test that you know is going to be mentally exhausting and will last two hours. You are entirely free to plan your day. Considering only your "internal clock", which ONE of the four testing times would you choose?*

_____8:00-10:00am (6)
_____11:00am-1:00pm (4)
_____3:00-5:00pm (2)
_____7:00-9:00pm (0)

12. If you got into bed at 11pm, how tired 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 are you most likely to do?

_____ Will wake up at usual time, but will not fall back asleep (4)
_____ Will wake up at usual time and will doze thereafter (3)
_____ Will wake up at usual time, but will fall asleep again (2)
_____ Will not wake up until later than usual (1)

14. *One night you have to remain awake between 4-6am in order to carry out a night watch. You have no time commitments the next day. Which one of the alternatives would suit you best?*

_____ Would not go to bed until the watch is over (1)
_____ Would take a nap before and sleep after (2)
_____ Would take a good sleep before and nap after (3)
_____ Would sleep only before the watch (4)

15. *You have two hours of hard physical work. You are entirely free to plan your day. Considering only your internal "clock", which of the following times would you choose?*

_____8:00-10:00am (4)
_____11:00am-1:00pm (3)
_____3:00-5:00pm (2)
_____7:00-9:00pm (1)

16. *You have decided to do physical exercise. A friend suggests that you do this for one hour twice a week, and the best time for her is between 10:00-11:00pm. Bearing in mind only your internal "clock", how well do you think you would perform?*

_____Would be in good form (1)
_____Would be in reasonable form (2)
_____Would find it difficult (3)
_____Would find it very difficult (4)

17. *Suppose you can choose your own work hours. Assume that you work a five-hour day (including breaks), your job is interesting, and you are paid based on your performance. At approximately what time would you choose to begin?*

_____ 5 hours starting between 4-8am (5)
_____ 5 hours starting between 8-9am (4)
_____5 hours starting between 9am-2pm (3)
_____5 hours starting between 2pm-5pm (2)
_____5 hours starting between 5pm-4am (1)

18. At approximately what time of day do you usually feel your best?

_____ 5-8am (5)
_____ 8-10am (4)
_____ 10am-5pm (3)
_____ 5-10pm (2)
_____ 10pm-5am (1)

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

_____Definitely a morning type (6)
_____More of a morning than an evening type (4)
_____More of an evening than a morning type (2)
_____Definitely an evening type (0)

Name _____

Sleep Medicine Specialists

Sleep Hygiene Practice Scale

How often do you do the following activities during an average week?

Read in bed..... _____ times a week
Watch TV in bed..... _____ times a week
Eat in bed..... _____ times a week
Work in bed..... _____ times a week
Argue in bed..... _____ times a week
Worry in bed..... _____ times a week
Use sleeping medication (prescription or over the counter)..... _____ times a week

Drink beverages containing caffeine within 4 hours of bedtime. _____ times a week
Use alcohol to help you sleep..... _____ times a week
Smoke more than a pack of cigarettes..... _____ times a week
Go to bed hungry or thirsty..... _____ times a week
Drink more than 3 ounces of alcohol (e.g. 3 mixed drinks, beers, 3 glasses of wine) before bedtime..... _____ times a week
Take medications / drugs with caffeine within 4 hours of Bedtime..... _____ times a week
Exercise strenuously within 2 hours of bedtime..... _____ times a week
Exercise in the afternoon or early evening ..... _____ times a week
Sleep approximately the same length of time each night..... _____ times a week
Set aside time to relax before bedtime..... _____ times a week

Have your sleep disturbed by light..... _____ times a week
Have your sleep disturbed by noise..... _____ times a week
Have your sleep disturbed by a bed partner..... _____ times a week
Have a comfortable nighttime temperature in your bed or bedroom..... _____ times a week

Name:_____

Sleep Medicine Specialists

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? 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	
Watching TV	
Sitting inactive in a public place (eg, a theater or meeting)	
As a passenger in a car for an hour witout a break	
Lying down to rest in the afternoon when the circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

The Pre-Sleep Arousal Scale

Instructions to patient

This scale is fairly self-explanatory. We are interested to find out about how you are feeling in your mind and in your body before you fall asleep. Please describe how intensely you experience each of the symptoms mentioned below as you attempt to fall asleep, by circling the appropriate number.

	Not at all	Slightly	Moderate	A lot	Extremely
1. Worry about falling asleep	1	2	3	4	5
2. Review or ponder the events of the day	1	2	3	4	5
3. Depressing or anxious thoughts	1	2	3	4	5
4. Worry about problems other than sleep	1	2	3	4	5
5. Being mentally alert, active	1	2	3	4	5
6. Can't shut off your thoughts	1	2	3	4	5
7. Thoughts keep running through your head	1	2	3	4	5
8. Being distracted by sounds, noise in the environment	1	2	3	4	5
9. Heart racing, pounding or beating irregularly	1	2	3	4	5
10. A jittery, nervous feeling in your body	1	2	3	4	5
11. Shortness of breath or labored breathing	1	2	3	4	5
12. A tight, tense feeling in your muscles	1	2	3	4	5
13. Cold feeling in your hands, feet or your body in general	1	2	3	4	5
14. Have stomach upset (knot or nervous feeling in stomach, heartburn, nausea, gas, etc.)	1	2	3	4	5
15. Perspiration in palms of your hands or other parts of your body	1	2	3	4	5
16. Dry feeling in mouth or throat	1	2	3	4	5

Source: P. Nicassio, et al. The phenomenology of the pre-sleep state: The development of the Pre-Sleep Arousal Scale. *Behaviour Research and Therapy*, 23, 263-271.

Daytime Alertness Scale

Please circle one number that indicates how much the statement applies to you.

	Not at all	A Little	Quite a Bit	Extremely
1. I am well organized.	**0**	**1**	**2**	**3**
2. I am slow to awaken in the mornings.	0	1	2	3
3. I am a very careful worker.	**0**	**1**	**2**	**3**
4. My mind is always going.	0	1	2	3
5. I think a lot about feelings.	**0**	**1**	**2**	**3**
6. Bright lights, crowds, noises, or traffic bother me.	0	1	2	3
7. Evenings are my best time.	**0**	**1**	**2**	**3**
8. I cannot take naps, even if I try.	0	1	2	3
9. I tend to anticipate problems.	**0**	**1**	**2**	**3**
10. My bedroom is a mess.	0	1	2	3
11. I take things personally.	**0**	**1**	**2**	**3**
12. I get rattled when a lot happens at once.	0	1	2	3
13. I am good at details.	**0**	**1**	**2**	**3**
14. I have trouble falling asleep.	0	1	2	3
15. I am a cautious person.	**0**	**1**	**2**	**3**
16. In bed at night, my thoughts keep going.	0	1	2	3
17. A sudden, loud noise would cause me a prolonged reaction.	**0**	**1**	**2**	**3**
18. I am overly conscientious.	0	1	2	3
19. Caffeine affects me strongly.	**0**	**1**	**2**	**3**
20. When things go wrong, I tend to get depressed.	0	1	2	3
21. My routine is predictable.	**0**	**1**	**2**	**3**
22. Some thoughts return too often.	0	1	2	3
23. I take a long time to make decisions.	**0**	**1**	**2**	**3**
24. Alcohol makes me sleepy.	0	1	2	3
25. I get tearful easily.	**0**	**1**	**2**	**3**
26. I keep thinking about the same things long after they happened.	0	1	2	3

Beliefs and Attitudes about Sleep Scale

Instructions to patient

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, circle the number that corresponds to your own *personal belief.* Please respond to all items even though some may not apply directly to your own situation.

	Strongly Disagree								Strongly Agree
Example	1	2	3	4	5	(6)	7	8	9	10

1. I need 8 hours of sleep to feel refreshed and function well during the day.

1	2	3	4	5	6	7	8	9	10

2. When I don't get proper amount of sleep on a given night, I need to catch up on the next day by napping or on the next night by sleeping longer.

1	2	3	4	5	6	7	8	9	10

3. I am concerned that chronic insomnia may have serious consequences on my physical health.

1	2	3	4	5	6	7	8	9	10

4. I am worried that I may lose control over my abilities to sleep.

1	2	3	4	5	6	7	8	9	10

5. After a poor night's sleep, I know that it will interfere with my daily activities on the next day.

1	2	3	4	5	6	7	8	9	10

6. In order to be alert and function well during the day, I believe I would be better off taking a sleeping pill rather than having a poor night's sleep.

1	2	3	4	5	6	7	8	9	10

7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.

1	2	3	4	5	6	7	8	9	10

8. When I sleep poorly on one night, I know it will disturb my sleep schedule for the whole week.

Strongly Disagree — Strongly Agree

1 2 3 4 5 6 7 8 9 10

9. Without an adequate night's sleep, I can hardly function the next day.

1 2 3 4 5 6 7 8 9 10

10. I can't ever predict whether I'll have a good or poor night's sleep.

1 2 3 4 5 6 7 8 9 10

11. I have little ability to manage the negative consequences of disturbed sleep.

1 2 3 4 5 6 7 8 9 10

12. When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.

1 2 3 4 5 6 7 8 9 10

13. I believe insomnia is essentially the result of a chemical imbalance.

1 2 3 4 5 6 7 8 9 10

14. I feel that insomnia is ruining my ability to enjoy life and prevents me from doing what I want..

1 2 3 4 5 6 7 8 9 10

15. Medication is probably the only solution to sleeplessness.

1 2 3 4 5 6 7 8 9 10

16. I avoid or cancel obligations (social, family) after a poor night's sleep.

1 2 3 4 5 6 7 8 9 10

Motivation for Change Index

1. Because of my sleep problem I can't (Please List)

   _____
   _____
   _____
   _____
   _____

2. If there were a treatment we could use that would, as of tomorrow, fix your sleep problem---in what way(s) would your life be better?

   _____
   _____
   _____
   _____
   _____

3. If there were a treatment we could use that would fix your sleep problem how many hours per week would you be willing to invest in the process?

   _____ 1 hour ____ 2 hours ____ 4 hours ____ 8 hours ____ 10 hours

4. If there were a treatment we could use that would fix your sleep problem BUT it would take time, how long would you be willing to wait?

   _____ 1 week ____ 2 weeks ____4 weeks ____8 weeks ____ 10 weeks

5. If there were a treatment we could use that would fix your sleep problem BUT to get better it would mean that you'd get worse before you get better, how much worse would you be willing to get?

   _____ 10% _____ 20% _____ 40% _____ 80% _____ 100%

6. To make a difference in your life, how much improvement would represent a real accomplishment?

   _____ 10% _____ 20% _____ 40% _____80% _____ 100%