SLEEP QUESTIONNAIRE

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. This information will be held in the strictest confidence:

Describe you main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past:

_____

_____

_____

SLEEP HISTORY

Do you experience any of the following?

Snoring ❑ Insomnia ❑ Leg Cramps ❑ Stopping Breathing ❑ Excessive Daytime Sleepiness ❑

What time do you go to sleep _____

How long does it take you to fall asleep? _____

What time do you wake up on the weekdays? _____ On the weekends? _____

How many times do you wake up during the night? _____

Do you have feelings of depression/anxiety?	Yes	❑	No	❑
Do you have drop attacks during the day?	Yes	❑	No	❑
Do you have hallucinations upon falling asleep or upon waking?	Yes	❑	No	❑
Do you have crawling sensations in your legs?	Yes	❑	No	❑
Do you work split shifts or variable shifts?	Yes	❑	No	❑
Do you usually drink caffeine within two hours of going to bed?	Yes	❑	No	❑
Awaken from sleep short of breath or gasping for air	Yes	❑	No	❑
Awaken at night with heartburn, belching or cough	Yes	❑	No	❑
Snore	Yes	❑	No	❑
Sweat excessively at night	Yes	❑	No	❑
Notice your heart pounding or beating irregularly during the night	Yes	❑	No	❑
Fall asleep during the day	Yes	❑	No	❑
Fall asleep involuntarily or while driving	Yes	❑	No	❑
Fall asleep or lose muscle tone when laughing or crying	Yes	❑	No	❑
Feel unable to move (paralyzed) when waking or falling asleep	Yes	❑	No	❑
Experience vivid dreamlike scenes upon awakening or falling asleep	Yes	❑	No	❑
Remember your dreams	Yes	❑	No	❑
Kick or have body jerks during the night	Yes	❑	No	❑
Experience crawling and aching feelings in your legs	Yes	❑	No	❑

Chart #: _____