NAME:____
(last) (first) (initial)

6PAH

How did you hear about our sleep center?______________________

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

2. How often does this problem occur?
   - ☐ almost every night
   - ☐ for periods of at least one week
   - ☐ irregularly
   - ☐ other:______________________

3. How long has this problem bothered you?
   - ☐ longer than 2 years
   - ☐ 1 to 2 years
   - ☐ several months
   - ☐ within the last 3 months
   - ☐ within the last month

4. On the scale below, please estimate the severity of your problem(s) by marking the appropriate box.
   - ☐ mildly severe
   - ☐ moderately severe
   - ☐ very severe
   - ☐ extremely severe
   - ☐ totally incapacitating

5. How strongly do you want help with your problem?
- ☐ very
- ☐ moderately
- ☐ mildly
- ☐ could do without it

6. How do you describe your sleep problem? Check all that apply to you.
- ☐ difficulty falling asleep
- ☐ wake up during the night
- ☐ wake up early in the morning
- ☐ excessive daytime sleepiness
- ☐ difficulty awakening
- ☐ other: ______________________________

7. Do any other members of your family have sleep problems? Please explain:

____

____

____

____

____

8. Have you ever consulted with any of the following to help you with a sleep problem or with daytime sleepiness?

☐ general practitioner	☐ chiropractor
☐ obstetrics / gynecology	☐ osteopath
☐ cardiologist	☐ nutritionist
☐ other internists	☐ counselor
☐ psychiatrist	☐ social worker
☐ other physician	☐ nurse
☐ clinical psychologist	☐ clergyman
☐ other: ______________________________	

9. What other treatments have you received?

____

____

10. Is your present work situation satisfactory?

____

____

11. PLEASE RATE HOW OFTEN YOU:	NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
Awaken from sleep short of breath					
Awaken with heartburn, belching, or cough					
Snore					
Snore loudly enough that others complain					
Have trouble sleeping when you have a cold					
Suddenly wake up gasping for breath					
Have breathing problems at night (observed by self or others)					
Sweat excessively at night					
Notice your heart pounding or beating irregularly during the night					
Fall asleep during the day					
Fall asleep involuntarily					
Fall asleep while driving					
Fall asleep during physical effort					
Fall asleep while laughing or crying					
Experience loss of muscle tone when extremely emotional					
Have trouble at school or work because of sleepiness					
Feel unable to move (paralyzed) when waking or falling asleep					
Experience vivid dream – like scenes upon awakening or falling asleep					
Feel afraid of going to sleep					
Have nightmares					
Remember your dreams					
Have thoughts racing through your mind					
Feel sad and depressed					
Have anxiety (worry about things)					
Have muscular tension					
Notice parts of your body jerking					
Kick during the night					
Experience a crawling / aching feeling in your legs					
Experience any type of leg pain during the night					
Have morning jaw pain					
Grind your teeth during sleep					
Are bothered by pain during the day					
Wake up feeling stiff in the mornings					

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12. Check any of the following that apply to you:

- ☐ Headaches
- ☐ Palpitations
- ☐ Dizziness
- ☐ Nightmares
- ☐ Feel tense
- ☐ Depressed
- ☐ Insomnia
- ☐ Fatigue
- ☐ Alcoholism
- ☐ Take drugs
- ☐ Tremors
- ☐ Shy with people
- ☐ Fainting spells
- ☐ Suicidal ideal
- ☐ Take sedatives
- ☐ Overambitious
- ☐ No appetite
- ☐ Sexual problems
- ☐ Memory problems
- ☐ Feel panicky
- ☐ Unable to relax
- ☐ Stomach trouble
- ☐ Can't keep a job
- ☐ Home conditions bad
- ☐ Can't make decisions
- ☐ Can't make friends
- ☐ Financial problems
- ☐ Inferiority feelings
- ☐ Concentration difficulties
- ☐ Don't like weekends / vacations
- ☐ Unable to have a good time
- ☐ Bowel disturbances
- ☐ Take antacids regularly (tums, tagamet, etc.)
- ☐ Others: ______________________

13. Check any of the following words that apply to you:

- ☐ Ugly
- ☐ Useless
- ☐ Guilty
- ☐ Evil
- ☐ Naive
- ☐ Cowardly
- ☐ Anxious
- ☐ Bored
- ☐ Panicky
- ☐ Lonely
- ☐ Confident
- ☐ Unloved
- ☐ Confused
- ☐ Deformed
- ☐ Repulsive
- ☐ Restless
- ☐ Hostile
- ☐ Agitated
- ☐ Worthless
- ☐ Depressed
- ☐ Unassertive
- ☐ Aggressive
- ☐ Unattractive
- ☐ Considerate
- ☐ Attractive
- ☐ Sympathetic
- ☐ Worthwhile
- ☐ Intelligent
- ☐ Incompetent
- ☐ Not confident
- ☐ Inadequate (stupid)
- ☐ Life is empty
- ☐ Can't do anything right
- ☐ Full of hate
- ☐ In conflict
- ☐ A "nobody"
- ☐ Morally wrong
- ☐ Horrible thoughts
- ☐ Full of regrets
- ☐ Misunderstood
- ☐ Others: ______________________

14. Does your sleep problem disturb your sex life? (provide any information about any significant relationships)

____

____

____

15. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activities? If so, how?

____

____

____

16. How many hours of sleep do you usually get per night? ______________________

17. What time do you usually go to bed on weekdays? ____________ weekends? ____________

18. How long does it take for you to fall asleep? ______________________

19. How many times do you typically wake up at night? ______________________

20. If you wake up, on the average, how long do you stay awake? ______________________

21. If you do awaken during the night (after you first fall asleep) which part(s) of your sleep period is it?

☐ soon after falling asleep ☐ middle of the night ☐ early morning

22. What do you usually do when you awaken during the night? ____________________

23. What time do you usually awaken in the morning on weekdays? __________ weekends? __________

24. On the average, how long do you stay in bed after waking up in the morning? ______________

25. Do you usually (check all that apply to you):
- ☐ sleep with someone in your bed
- ☐ sleep with someone in your room
- ☐ provide assistance to someone during the night (child, invalid, bed partner, animal)

26. Is your sleep often disturbed by (check all that apply):
- ☐ heat
- ☐ cold
- ☐ noise
- ☐ light
- ☐ bed partner
- ☐ not being in your usual bed
- ☐ other: ____________________

27. Are your sleep habits on weekends different from the rest of the week?
☐ No ☐ Yes (please describe): ____________________

28. With whom are you now living? (wife, husband, children, parents, etc. please list age of each)

____

____

29. Do you work split shifts or rotating (variable) shifts? ____________________

30. Do you usually drink coffee or tea within 2 hours before you go to bed? ☐ Yes ☐ No

31. Do you do physical exercise before bedtime? ☐ Yes ☐ No

32. Do you read before falling asleep? ☐ Yes ☐ No

33. Do you watch TV in bed before falling asleep? ☐ Yes ☐ No

34. Do you take naps during the afternoon or evening? ☐ Yes ☐ No

35. Do you feel refreshed after a short (10 – 15 minute) nap? ☐ Yes ☐ No

36. How do you feel after an average night of sleep?
- ☐ usually drowsy and / or tired – if so for how long? ☐ 1 hour ☐ 2 hours ☐ 3 hours
- ☐ most of the time good
- ☐ consistently good

37. Do you feel better during the: ☐ morning ☐ afternoon ☐ evening

38. Do you take any kind of medication?

NAME	AMOUNT	HOW OFTEN	REASON

39. List your consumption of the following per day:

Coffee: ______________________ Chocolate: ______________________

Sodas: ______________________ Alcohol: ______________________

Tea: ______________________ Nicotine: ______________________

Other Caffeinated Beverages: ______________________

Over the counter drugs: ______________________

Other drugs: ______________________

40. What is your personal interpretation as to why you have your particular sleep / wake problem?

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41. Please describe any other information pertaining to your sleep or wakefulness not previously described.

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Thank you for your responses. This information will be very important in the evaluation of your problem.

Patient Signature: ______________________ **Date:** _____/_____/_____ **Time:** __________

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