SLEEPBetterTexas
Insomnia Clinics

Sleep History Questionnaire

Part I New Client Information

Name: _____ Birthdate: _____ M___ F___

Address: _____ Best phone to reach you: _____

Address (line 2): _____ Social Security No. _____

Education (years of school): _____ Occupation: _____

Marital Status: _____ Referred by: _____

Medicare # (if applicable): _____ Medicare Secondary: _____

Appointments must be cancelled 24 hours in advance to avoid charge.

Part II Sleep History

A. Sleep History

1. Please describe your sleep disturbance: _____
   _____
   _____
   _____

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

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying awake	0	1	2	3	4
Problem waking up too early	0	1	2	3	4

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

Very Satisfied		Moderately		Very Dissatisfied
0	1	2	3	4

4. To what extent do you feel your sleep problem INTERFERES with functioning (e.g., daytime functioning, work functioning, mood, etc.)?

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

5. How NOTICABLE to others do you think your sleeping problems in terms of impairing the quality of your life?

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

6. How WORRIED or distressed are you about your sleep problem?

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

7. Estimate how many hours of sleep you get:

   a) on a good night _____ b) on a bad night _____

8. How long does it take you to fall asleep?

   a) on a good night _____ b) on a bad night _____

9. How many times do you wake up during the night?

   a) on a good night _____ b) on a bad night _____

10. How long are you awake during the night after initially falling to sleep?

    a) on a good night _____ b) on a bad night _____

11. How long have you had this problem? _____

    Has it increased in severity, and if so, over what period of time? _____

12. What do you feel is the major cause(s) of your sleep problem? _____
    _____
    _____
    _____

13. Did you have this sleep problem as a child? Yes No (circle one)
    Please describe the problem _____
    _____
    _____
    _____
    _____
    _____
    _____

B. Daytime Functioning: Please circle the number that corresponds to the degree to which the following daytime symptoms were bothersome or caused distress to you. If you did not experience the symptoms during the day all this week, please circle "Did not occur. Because we are interested in daytime symptoms, if you experienced them in bed at night only, please circle "Did not occur".

Symptom	Did not occur	Not at all troubling	Mildly troubling	Moderately troubling	Extremely troubling
1. Falling asleep unintentionally	0	1	2	3	4
2. Fatigue	0	1	2	3	4
3. Difficulty functioning	0	1	2	3	4
4. Difficulty with school/work/daily chores	0	1	2	3	4
5. Difficulty concentrating	0	1	2	3	4
6. Muscle tension	0	1	2	3	4
7. Worry about sleeping	0	1	2	3	4

Symptom	Did not occur	Not at all troubling	Mildly troubling	Moderately troubling	Extremely troubling
8. Tired	0	1	2	3	4
9. Irritable	0	1	2	3	4
10. Depressed	0	1	2	3	4
11. Washed-out	0	1	2	3	4
12. Difficulty paying attention	0	1	2	3	4
13. Tense	0	1	2	3	4
14. Muscle pain	0	1	2	3	4
15. Groggy	0	1	2	3	4
16. Anxious	0	1	2	3	4
17. Trouble starting tasks	0	1	2	3	4
18. Memory problems	0	1	2	3	4
19. Frustrated	0	1	2	3	4
20. Achiness	0	1	2	3	4
21. Grouchy	0	1	2	3	4
22. Light-headed	0	1	2	3	4
23. Confused	0	1	2	3	4
24. Headache	0	1	2	3	4
25. Angry	0	1	2	3	4
26. Not wanting to socialize	0	1	2	3	4
27. Upset stomach	0	1	2	3	4
28. Nervous	0	1	2	3	4
29. Diarrhea	0	1	2	3	1
30. Unmotivated	0	1	2	3	1

1. How likely are you to doze off or fall asleep in the following situations when you are tired? This refers to your usual way of life in recent times? Even if you have not experienced these things recently, try to work out how they have affected you. Use the following scale to choose the most appropriate number for each situation.

0	=	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 (theater/meeting)	_____
As a passenger in a car for an hour, without a break	_____
Lying down in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, stopped for a few minutes, in traffic	_____

2. Below is a series of statements regarding fatigue. By fatigue we mean a sense of tiredness, lack of energy, or total body give-out. Please read each statement and circle a number from 1 to 7 that indicates your agreement with each statement where 1 indicates you strongly disagree, and 7 indicates you strongly agree. Please answer the questions as they apply to the past week.

	STRONGLY DISAGREE			NEUTRAL			STRONGLY AGREE
a. My motivation when I'm fatigued	1	2	3	4	5	6	7
b. Exercise brings on my fatigue	1	2	3	4	5	6	7
c. I am easily fatigued	1	2	3	4	5	6	7
d. Fatigue interferes with my physical functioning	1	2	3	4	5	6	7
e. Fatigue causes frequent problems for me	1	2	3	4	5	6	7

	STRONGLY DISAGREE			NEUTRAL			STRONGLY AGREE
f. My fatigue prevents sustained physical functioning	1	2	3	4	5	6	7
g. Fatigue interferes with carrying out certain duties and responsibilities	1	2	3	4	5	6	4
h. Fatigue is among my three most disabling symptoms	1	2	3	4	5	6	7
i. Fatigue interferes with my work, family, and social life	1	2	3	4	5	6	7

3. On the graph below, indicate how sleepy you generally feel at the most appropriate corresponding number from the scale below and circle the most appropriate number.

9:00am	1	2	3	4	5	6	7
Noon	1	2	3	4	5	6	7
6:00pm	1	2	3	4	5	6	7
9:00pm	1	2	3	4	5	6	7

1 = Feeling active, vital, and wide awake
2 = Functioning at a high level but not at peak, able to concentrate
3 = Relaxed, awake, not full alertness, responsive
4 = A little foggy, not at peak, let down
5 = Fogginess, beginning to lose interest in staying awake, slowed down
6 = Sleepiness, prefer to be laying down, fighting sleep, woozy
7 = Almost in revere, sleep onset soon, lost struggle to stay awake

C. Sleep Habits

1. a) On average, what is your normal bedtime? _____
   b) On average, what time do you get out of bed in the morning? _____

2. Do you have a standard wake up time you use?
   a) 7 days per week? Yes No (circle one)
   b) 5 Days a week Yes No (circle one)

3. Does your job require you to change shifts? Yes No (circle one)

4. How much do you travel across time zones? _____ times per month

5. Do you have a bed partner? Yes No (circle one)

   If yes, are you and your bed partner having any problems that might be interfering with your sleep? Yes No (circle one)
   If yes, please explain _____
   _____

6. How many nights per week do you lie in bed for at least 30 minutes either trying to fall asleep or trying to fall back to sleep?
   _____ nights per week.

7. How many mornings during the week do you wake up at least 1 hour before your normal wake-up time and cannot return to sleep?
   _____ mornings per week.

8. How often do you do the following activities in bed during the average week? Please only use one number on each blank.

ACTIVITY	# per week
a. Take a nap	_____
b. Go to bed hungry	_____
c. Go to bed thirsty	_____
d. Smoke more than one pack of cigarettes	_____
e. Use sleep medication (prescription or over the counter)	_____
f. Drink beverages containing caffeine (e.g., coffee, tea, cola) within 4 hours of bedtime	_____
g. Drink more than 3 ounces of alcohol (e.g., 3 mixed drinks, 3 beers, 3 glasses of wine) within 2 hours of bedtime	_____
h. Take medications/drugs with caffeine within 4 hours of bedtime	_____
i. Worry about your ability to sleep at night, while preparing for bed	_____

ACTIVITY	# per week
j. Worry about your ability to sleep at night, during the day	_____
k. Use alcohol to facilitate or bring on sleep	_____
l. Exercise strenuously 2 hours before bed	_____
m. Have your sleep disturbed by the light	_____
n. Have your sleep disturbed by noise	_____
o. Have your sleep disturbed by your bed partner (put N/A if you have none)	_____
p. Sleep approximately the same length every night	_____
q. Set aside time to relax before bedtime	_____
r. Exercise in the afternoon or early evening	_____
s. Have a comfortable temperature in your bedroom	_____

D. Additional Sleep Complaints

If you have a bed partner have them help you answer the next three questions about your sleep.

1. Has anyone ever told you that your snore loudly?
   Yes No (circle one)

   If yes, has your snoring caused people to refuse to sleep in the same room with you?
   Yes No (circle one)

2. Has anyone ever told you that you stop breathing while you sleep, or that you wake up gasping for breath? Yes No (circle one)

   If yes, how often has this been noted? _____

   If yes, how long have you stopped breathing? _____

3. Has anyone ever noticed your legs twitching during the night?
   Yes No (circle one)

4. Have you ever been unable to move when falling asleep or immediately upon waking?
   Yes No (circle one)

5. Have you ever had episodes of sudden muscle weakness (paralysis or inability to move) when laughing, angry, or in other emotional situations?
   Yes No (circle one)

6. Indicate how many times per month you have noticed that you:

   a. Wake up with a morning headache _____ times per month

   b. Notice a deep creeping sensation in your calves or thighs during the night _____ times per month

   c. Wake up confused and wander during the night _____ times per month

   d. Have nightmares _____ times per month

   e. Have fearful thoughts or images as you are falling asleep _____ times per month

E. Medication History

1. Currently, how many times during the month do you take medications to help you sleep? _____ times per month

2. Currently, how much alcohol do you use to help you sleep?

   _____ times per month _____ amount per night _____ how long

3. Please list all medications, prescribed and over-the-counter, you are presently taking or have recently stopped taking and the reason for taking the medications.

Medication	Doses/times per day	Reason	Current?

4. How much of the following do you consume during the average day

Alcohol	_____
Coffee (with caffeine)	_____
Tea (with caffeine)	_____
Soft drink (with caffeine)	_____
Cigarettes	_____
Other tobacco products	_____

5. Describe any other treatments that you have had to help you sleep and how well the previous treatments worked _____

_____

_____

_____

_____

_____

_____

F. Attitudes About Sleep: 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 might not directly apply to your situation.

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

0	1	2	3	4	5	6	7	8	9	10
Strongly Disagree										**Strongly Agree**

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

0	1	2	3	4	5	6	7	8	9	10
Strongly Disagree										**Strongly Agree**