RIVERSIDE
SLEEP DISORDER INSTITUTE

Sleep Disorder Institute
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Watseka, IL 60970
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www.RiversideHealthcare.org

Accredited by the American Academy of Sleep Medicine

General Information

Name:_____ Age: _____ Date of Birth: _____

Are you a shift worker? ☐ Yes ☐ No

Referral Source: ☐ Physician ☐ TV ☐ Newspaper ☐ Friend ☐ Other _____

Regular Physician _____ Phone _____

Address _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have mot done some of these things recently, try to work out how they would have affected you. Use the following scale to chose 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**			
Circle one number for each statement	Never	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when the circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

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Questions About Your Sleep and Wake Behavior

1. Please state in your own words the reason you or your doctor contacted the Sleep Disorder Institute?

   _____

   _____

About Falling Asleep

2. What time do you usually try to fall asleep? _____ ☐ a.m. ☐ p.m.
3. Does this time vary? ☐ Yes ☐ No

   If So, how? _____
4. How long does it usually take you to fall asleep?_____Hours _____ Minutes
5. How many days each week does it take you more than 30 minutes to fall asleep? _____ Days
   More than 60 minutes? _____ Days
6. When falling asleep or trying to fall asleep, how often do you:

Check one box for each statement	***Never***	***Sometimes***	***Often***
a. have thoughts racing through your mind?	☐	☐	☐
b. feel sad or depressed?	☐	☐	☐
c. have anxiety (worry about things)?	☐	☐	☐
d. feel muscular tension?	☐	☐	☐
e. feel afraid of not being able to sleep?	☐	☐	☐
f. feel unable to move?	☐	☐	☐
g. have creeping, crawling, aching or twitching feelings in your legs (feel like you have to move them)?	☐	☐	☐
h. have vivid, dream-like scenes even though you know you are totally asleep?	☐	☐	☐
i. have any kind of pain or discomfort	☐	☐	☐
j. feel afraid of the dark or anything else?	☐	☐	☐
k. suddenly become aware or alert?	☐	☐	☐

7. On average, how many hours of sleep do you get each night? _____ Hours _____ Minutes

About Sleeping

8. How much does your nightly amount of sleep vary? From _____ hours and _____minutes to _____ hours and _____ minutes
9. How many times do you usually awaken each night? _____

   Do you have trouble getting back to sleep? ☐ Yes ☐ No
10. On a typical night, what is your longest period of wakefulness? _____Hours _____ Minutes
11. How long are you awake all together during the night? _____Hours _____ Minutes
12. If you awaken during the night, is it usually during the: ☐ first half of the sleep period ☐ second half of the sleep period

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13. How often do you:

Check one box for each statement	*Never*	*Sometimes*	*Often*
a. feel afraid you won't return to sleep after awakening?	☐	☐	☐
b. sleep with someone else in the bed?	☐	☐	☐
c. sleep with someone else in your room?	☐	☐	☐
d. have restless, disturbed sleep?	☐	☐	☐
e. get up at night to attend to your children or something else?	☐	☐	☐
f. snore loudly?	☐	☐	☐
g. feel your heart pounding during the night?	☐	☐	☐
h. sweat a lot during the night?	☐	☐	☐
i. walk in your sleep?	☐	☐	☐
j. fall out of bed while asleep?	☐	☐	☐
k. wake up screaming, violent or confused?	☐	☐	☐
l. have unusual movements while sleeping?	☐	☐	☐
m. wet the bed?	☐	☐	☐
n. have dreams?	☐	☐	☐
o. grind your teeth at night	☐	☐	☐

14. My sleep is frequently disturbed by: (Check all that are true)

- ☐ heat
- ☐ cold
- ☐ light
- ☐ noise
- ☐ asthma
- ☐ noise or movement of your bed partner
- ☐ cough
- ☐ shortness of breath
- ☐ choking
- ☐ creeping, crawling or aching feeling in your legs (like you have to move them)
- ☐ indigestion, gas or heartburn
- ☐ hunger
- ☐ thirst
- ☐ need to urinate
- ☐ chest pain
- ☐ frightening dreams

About Waking Up

15. What time do you usually have your final awakening? _____ ☐ a.m. ☐ p.m.
16. What time do you usually get out of bed after your final awakening? _____ ☐ a.m. ☐ p.m.
17. How much does your final awakening time vary? From _____ hours and _____minutes to _____ hours and _____ minutes
18. How often do you:

Check one box for each statement	*Never*	*Sometimes*	*Often*
a. depend on an alarm clock to wake you?	☐	☐	☐
b. "sleep in" in the morning (more than one hour) past your usual wake-up time?	☐	☐	☐
c. have a very hard time waking up?	☐	☐	☐
d. feel unable to move when waking up?	☐	☐	☐
e. have dream-like images when waking up even though you know you are not asleep?	☐	☐	☐
f. wake up confused or disoriented?	☐	☐	☐

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g. wake up with a headache?	☐	☐	☐
h. wake up nauseous (sick to your stomach)?	☐	☐	☐
i. wake up with a dry mouth?	☐	☐	☐
j. wake up 1 or 2 hours before you have to get up?	☐	☐	☐

About Daytime Functioning

19. How many naps do you take in a usual week?_____

20. How long do you usually sleep during a typical nap? _____Hours _____ Minutes

21. Are the naps refreshing? ☐ Yes ☐ No

22. How often do you:

Check one box for each statement	*Never*	*Sometimes*	*Often*
a. feel sleepy during the day?	☐	☐	☐
b. fall asleep unintentionally? Please give an example _____	☐	☐	☐
c. have thoughts racing through your mind?	☐	☐	☐
d. feel sad or depressed?	☐	☐	☐
e. have anxiety (worry about things)?	☐	☐	☐
f. feel muscular tension?	☐	☐	☐
g. feel weakness in your muscles when laughing, surprised, angry, excites, etc.?	☐	☐	☐

23. Does anyone in your family have a sleep problem? ☐ Yes ☐ No

Relationship to you	**Describe the Problem**
_____	_____
_____	_____
_____	_____
_____	_____

24. How much of the following fluids do you drink?

	During a Typical Day	*Within 2 hours before bedtime*
a. coffee: caffeinated	_____ cups	_____ cups
decaffeinated	_____ cups	_____ cups
b. tea	_____ cups	_____ cups
c. soda: caffeinated	_____ cups	_____ cups
d. beer	_____ cans/bottles	_____ cans/bottles
e. wine	_____ glasses	_____ glasses
f. other alcoholic beverages	_____ drinks	_____ drinks

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25. How much tobacco do you use during a 24 hour period?

☐ cigarettes_____packs/_____cigarettes ☐ cigars _____ ☐ pipe bowls _____ ☐ vap/ecig _____

26. How often do you use:

Check one box for each statement	*Never*	*Sometimes*	*Often*	*Doctor Prescribed*
a. marijuana?	☐	☐	☐	☐
b. cocaine?	☐	☐	☐	☐
c. hallucinogens (LSD, mescaline, angel dust, etc.)?	☐	☐	☐	☐
d. stimulants (uppers)?	☐	☐	☐	☐
e. depressants (downers)?	☐	☐	☐	☐
f. narcotics (heroin, morphine, opium, etc.)?	☐	☐	☐	☐

27. Please list the name of any pill for sleeping or to help you stay awake that you have taken in the PAST?

Name	**Did it help?**
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No

28. How many times a week do you participate in a sport or partake in some form of exercise? _____

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

_____

_____

31. How much time do you spend daily on a screen using a:

Computer _____

Tablet _____

Phone _____

TV _____

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Bed Partner Questionnaire

Patient Name _____ Date _____

Name of person filling out this form _____

I have observed this person's sleep: ☐ Never ☐ Once or Twice ☐ Often ☐ Every Night

Check any of the following behaviors that you have observed this person doing **WHILE ASLEEP**.

- ☐ light snoring
- ☐ choking
- ☐ grinding teeth
- ☐ noise
- ☐ bed wetting
- ☐ crying out
- ☐ awakening with pain
- ☐ becoming very rigid and/or shaking
- ☐ loud snoring
- ☐ pauses in breathing
- ☐ sleepwalking
- ☐ biting tongue
- ☐ sitting up in bed not awake
- ☐ head rocking or banging
- ☐ apparently sleeping even if s/he behaves otherwise
- ☐ occasional loud snorts
- ☐ twitching or kicking of legs during sleep
- ☐ twitching or jerking of arms during sleep
- ☐ getting out of bed but not awake

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ☐ Yes ☐ No

If yes, please explain _____