*Sleep*well to feel well

A Private Practice
Sleep Disorders Service

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LICENSED PSYCHOLOGIST

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Dear Patient:

Disrupted or unsatisfying sleep, daytime fatigue and daytime sleepiness all can have a wide range of causes. The attached questionnaire is designed for you to complete at home where you will have time to answer the questions thoughtfully, and refer to records if necessary. The questions cover quite a wide range of possibilities. Some of these as they bear on your sleep may be relevant and you may want to elaborate; others of these may be completely irrelevant (and in fact in some cases, if you have not had the experience the question asks about, you may not even understand the question!).

Please complete the questionnaire as fully and accurately as you can. For some questions, such as those which ask for dates or certain time estimates, it is often people's experience to not know the exact answer. For those, just give your best guess.

If there is time for me to receive it before our appointment, please mail the questionnaire to me at the address where you have your appointment. This will give me time to review it before you arrive for your first visit and allow us to use our office visit time to home in on what is causing your problem, and what we will do next. If there is not enough time, just bring it with you.

I look forward to meeting you.

PERSONAL INFORMATION:

NAME: ____________________________

ADDRESS: ____________________________

____

TELEPHONE: Home (   ) ________

Work (   ) ________

DATE OF BIRTH: __ __/__ __/__ __

SOC SEC # __ __ __/__ __/__ __ __ __

PERSON YOU WERE REFERRED BY:

NAME: ____________________

ADDRESS: ____________________

____

TELEPHONE: (   ) __________

PRIMARY PHYSICIAN IF DIFFERENT FROM PERSON WHO REFERRED YOU:

NAME: ____________________

ADDRESS: ____________________

____

TELEPHONE: (   ) __________

DATE OF OFFICE VISIT: __ __/__ __/__ __

PERSON COMPLETING FORM IF OTHER THAN PATIENT:

____

RELATIONSHIP TO PATIENT: ________

MARRIED ☐ How Long? ___________
DIVORCED ☐ How Long? ___________
WIDOWED ☐ SINGLE ☐

NUMBER OF:
CHILDREN _____
BROTHERS _____ SISTERS ______

CURRENT OCCUPATION: ______________

YEARS IN THIS EMPLOY: ______________

PRIOR OCCUPATION: ______________

IF RETIRED, YEAR OF RETIREMENT: _________

FOR OFFICE USE ONLY

CHIEF PROBLEMS:

IMPRESSIONS:

INSURANCE INFORMATION

PRIMARY INSURANCE:

NAME AND ADDRESS OF COMPANY:

INSURED'S ID NUMBER: __________

INSURED'S NAME: ________________

INSURED'S ADDRESS:

STREET # ________________

CITY, STATE, ZIP __________

INSURED'S POLICY GROUP OR FECA NUMBER

____

INSURED'S DATE OF BIRTH: __ /__/__

INSURED'S SEX ☐ Male ☐ Female

INSURED EMPLOYER OR SCHOOL NAME

____

INSURANCE PLAN OR PROGRAM NAME

____

IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES ☐ NO ☐

IF YES, PLEASE PROVIDE INFORMATION.

PLEASE BRING THIS WITH YOU TO YOUR FIRST VISIT

Today's date_____________ Your name_________________________

A. Symptoms

❖ Narrative description and history of problem(s):

Please use the following format to describe your symptoms in your own words.

1. Please describe in your own words the problem or problems you would like us to help you with. Provide as much detail as you think will be useful.

PROBLEM 1:____
____
____
____

About when did this problem start? _______________

What else was going on in your life at the time?

Has this problem changed in any way since it started?

If you answered yes, please describe as well as you can how the problem has changed, and include approximate dates for when each change occurred.

Description of Change	About when it happened
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PROBLEM 2:____
____
____
____

About when did this problem start? _______________

What else was going on in your life at the time?

Has this problem changed in any way since it started?

If you answered yes, please describe as well as you can how the problem has changed, and include approximate dates for when each change occurred.

Description of Change	About when it happened
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

PROBLEM 3:____
____
____
____

About when did this problem start? _______________

What else was going on in your life at the time?

Has this problem changed in any way since it started?

If you answered yes, please describe as well as you can how the problem has changed, and include approximate dates for when each change occurred.

Description of Change	About when it happened
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

As with all of these questions, please add additional pages if necessary.

2. **TO YOUR SPOUSE/BEDPARTNER/FAMILY MEMBER/OTHER INTIMATE PERSON IN YOUR LIFE:** Please use this space to describe what you have noticed which you think might be important to the sleep-wake problem described above (for instance, if the person completing this form -- in your perception --lives under a lot of stress, if there is a weight problem or medical problem of concern, etc.). Please also describe what you notice when she or he is sleeping (loud snoring, unusual movements, restlessness, sleep talking, etc.).

❖ SLEEP-WAKE DISORDERS SYMPTOM CHECKLIST

How often do you have the following symptoms or experiences?

Please use the scale on the right to answer these questions: ❖ Put a black mark (▌) through the number that shows how often a symptom NOW happens. ❖ Put an X (⊠) through the number that shows how often a symptom USED TO happen.	1.Rarely or none of the time. 2.Some of the time. 3.A lot of the time. 4.Most of the time 5.Always or almost all the time.				
1. I sleep well at night, wake up feeling refreshed, and am alert during the day.	1	2	3	4	5
2. I sleep poorly at night (have insomnia).	1	2	3	4	5
3. It takes me a long time to fall asleep.	1	2	3	4	5
4. I wake up a lot from sleep.	1	2	3	4	5
5. I wake up too early in the morning and can't get back to sleep.	1	2	3	4	5
6. My sleep is not refreshing.	1	2	3	4	5
7. During at least part of the night I doze instead of really sleep.	1	2	3	4	5

Please use the scale on the right to answer these questions: ❖ Put a black mark (▌) through the number that shows how often a symptom NOW happens. ❖ Put an X (⊠) through the number that shows how often a symptom USED TO happen.	1.Rarely or none of the time. 2.Some of the time. 3.A lot of the time. 4.Most of the time 5.Always or almost all the time.			
8. I feel so sleepy during the day that **I wish I could** take a nap.	1	2	3	4	5
9. I feel so sleepy during the day that I have **trouble resisting** taking a nap.	1	2	3	4	5
10. I have fallen asleep -- or almost fallen asleep -- when driving a car.	1	2	3	4	5
11. I don't really get *sleepy* but I do feel fatigue during some or all of the day.	1	2	3	4	5
12. I thrash in my sleep.	1	2	3	4	5
13. I do unusual things (like putting milk on the bookshelf instead of in the refrigerator) while apparently preoccupied.	1	2	3	4	5
14. I block on the names of people I know well, or on the words for common, familiar objects.	1	2	3	4	5
15. I have difficulty concentrating.	1	2	3	4	5
16. I get odd sensations on my skin, for instance as if my skin were covered with cobwebs.	1	2	3	4	5
17. I over-interpret shadows. For instance, I might think I see a cat running in front of my car when it is only a shadow cast by a lamp post onto the street.	1	2	3	4	5
18. I get irritable for no really good reason.	1	2	3	4	5
19. If things get complicated, I tend to let them slide because I don't have the energy or patience to deal with them.	1	2	3	4	5
20. I am very sensitive to even soft noises or lights that other people don't think are especially bright.	1	2	3	4	5
21. My eyes burn or blur when I am awake.	1	2	3	4	5
22. Some of the problems in items 2-21 above interfere with my life. I would be better off it I could correct at least one of them. This is true (use numbers to show how often this is true):	1	2	3	4	5

Please use the scale on the right to answer these questions: ❖ Put a black mark (▌) through the number that shows how often a symptom NOW happens. ❖ Put an X (⊠) through the number that shows how often a symptom USED TO happen.	1.Rarely or none of the time. 2.Some of the time. 3.A lot of the time. 4.Most of the time 5.Always or almost all the time.				
23. Sleep talking	1	2	3	4	5
24. Sleep walking	1	2	3	4	5
25. Acting out my dreams while asleep.	1	2	3	4	5
26. Waking up frightened for no obvious reason.	1	2	3	4	5
27. Waking up frightened because of a bad dream.	1	2	3	4	5
28. Waking up screaming.	1	2	3	4	5
29. If my body had its own way, I'd go to sleep and also **wake up** later than most people (like sleep from 3-11 AM).	1	2	3	4	5
30. If my body had its own way, I'd be a very early to bed **and** very early to rise person.	1	2	3	4	5
31. I wake up very hungry in the middle of the night.	1	2	3	4	5
32. I am always too hot or too cold.	1	2	3	4	5
33. I was a night owl when I was younger, or in college.	1	2	3	4	5
34. Bedwetting after age 5.	1	2	3	4	5
35. Frequent need to urinate during the sleep period.	1	2	3	4	5
36. LOUD snoring.	1	2	3	4	5
37. Times when breathing stops during sleep.	1	2	3	4	5
38. Significant weight gain.	1	2	3	4	5
39. Drenching nighttime sweats.	1	2	3	4	5
40. Waking with headaches.	1	2	3	4	5
41. Waking *because of* headaches.	1	2	3	4	5
42. Dry mouth on awakening.	1	2	3	4	5
43. Unusually thirsty upon awakening.	1	2	3	4	5

Please use the scale on the right to answer these questions: ❖ Put a black mark (▌) through the number that shows how often a symptom NOW happens. ❖ Put an X (⊠) through the number that shows how often a symptom USED TO happen.	1.Rarely or none of the time. 2.Some of the time. 3.A lot of the time. 4.Most of the time 5.Always or almost all the time.				
44. My jaw and/or temple aches when I wake up.	1	2	3	4	5
45. I grind or clench my teeth during sleep.	1	2	3	4	5
46. I awaken with sore or tired muscles for no apparent reason.	1	2	3	4	5
47. I sometimes hurt myself in my sleep.	1	2	3	4	5
48. I have thoughts constantly going through my head when I try to go to sleep, or when I try to return to sleep after waking up in the middle of my sleep period.	1	2	3	4	5
49. Sudden, often uncontrollable, urges to sleep during my waking hours.	1	2	3	4	5
50. Background sleepiness throughout the day.	1	2	3	4	5
51. Sudden muscle weakness of the face and/or knees, or at times of my whole body so much so that I might fall down, when having a strong emotion.	1	2	3	4	5
52. Feeling paralyzed while falling asleep.	1	2	3	4	5
53. Feeling paralyzed while waking up.	1	2	3	4	5
54. Dream-images that are very real, while falling asleep.	1	2	3	4	5
55. Dream-images that are very real, while waking up.	1	2	3	4	5
56. Dreaming during short naps (naps of 15 minutes or less).	1	2	3	4	5
57. I move my great toe, flex my calf muscles or actually kick -- rhythmically -- during sleep.	1	2	3	4	5
58. Crawling sensations in my legs that make me need to keep moving them, and sometimes make me have to get up and walk around to relieve the feeling.	1	2	3	4	5
59. Waking up with a cramp in my foot, calf and/or thigh.	1	2	3	4	5
60. Heartburn that goes up into my throat and sometimes into my nose during sleep.	1	2	3	4	5
61. A burning sensation in my throat during sleep, sometimes making me feel as if I were dying.	1	2	3	4	5
62. Waking up abruptly from sleep choking.	1	2	3	4	5
63. The harder I try to go to sleep, the more wakeful I get.	1	2	3	4	5
64. I can fall asleep almost anywhere, like in my recliner, but as soon as I get into bed I am wide awake.	1	2	3	4	5
65. I sleep better away from home.	1	2	3	4	5

Please use the scale on the right to answer these questions: ❖ Put a black mark (▌) through the number that shows how often a symptom NOW happens. ❖ Put an X (⊠) through the number that shows how often a symptom USED TO happen.	1.Rarely or none of the time. 2.Some of the time. 3.A lot of the time. 4.Most of the time 5.Always or almost all the time.			
66. My life has come to revolve around doing everything I can, such as playing relaxation tapes, so I can be sure I will sleep.	1	2	3	4	5
67. Especially when I am lying down on my left side, I can actually hear my heart beating in my ear.	1	2	3	4	5
68. When I am trying to fall asleep, my heart skips a beat.	1	2	3	4	5
69. When I am trying to fall asleep, my heart races.	1	2	3	4	5
70. I feel chest pains before or during sleep.	1	2	3	4	5

❖ OTHER QUESTIONS ABOUT YOUR SYMPTOMS

1. What is your best guess about what is causing your difficulty?

2. Note what you have done so far to remedy the problem, when you did it, who suggested it, and what the result was. Please use the following chart to do this:

Attempted solution	Whose suggestion	Start/Stop Date	Result

3. The following make my sleep or waking difficulties worse:

certain foods	___ No___ Yes	irregular sleep schedule	___ No___ Yes
problems at home	___ No___ Yes	uncomfortable bed	___ No___ Yes
problems at work	___ No___ Yes___	pain	___ No___ Yes
illness	___ No___ Yes	allergies	___ No___ Yes
insecure situation	___ No___ Yes	no obvious pattern	___ No___ Yes

Use this space to list other things which might make your sleep or waking difficulties worse:

4. The following make(s) my sleep/wake difficulties less severe:

certain foods	___ No___ Yes	regular sleep schedule	___ No___ Yes
home situation being all right	___ No___ Yes	comfortable bed	___ No___ Yes
work situation being all right	___ No___ Yes	alleviation of pain	___ No___ Yes
feeling well	___ No___ Yes	control of allergies	___ No___ Yes
secure situation	___ No___ Yes	no obvious pattern	___ No___ Yes

5. When is your major block of sleep (as opposed to when do you nap)?

My main sleep period is at night: ___ Yes ___ No
My main sleep period is in the daylight hours ___ Yes ___ No

My main sleep period is divided into several long naps, some of which can be during the daylight hours ___ Yes ___ No|
My main sleep period varies. No real pattern. ___ Yes ___ No|

If either of the next two are true, please explain why:

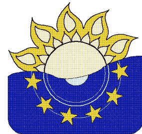
B. QUESTIONS ABOUT THINGS THAT MIGHT AFFECT YOUR SLEEP AND WAKEFULNESS

❖ SLEEP AND DAILY EVENT SCHEDULE:

1. My bedtime and wake up time are more or less the same seven days a week, across the year .__ Yes ___ No

If you answered YES, please answer the questions on the next page in the left column.

If you answered NO, please answer the questions on the next page in the right column.



ANSWER THE QUESTIONS IN THIS COLUMN **<u>ONLY IF YOU KEEP PRETTY REGULAR BEDTIME HOURS</u>** SEVEN DAYS A WEEK.

a. Your typical bedtime: __:__ AM PM
b. The *latest* time you might typically go to bed __:__ AM PM
c. The *earliest* time you might typically go to bed __:__ AM PM

d. Your typical time of awakening for the day __:__ AM PM
e. The *latest* you might wake for the day __:__ AM PM
f. The *earliest* you might wake for the day __:__ AM PM

If there are variations from these schedule, please describe:

ANSWER THE QUESTIONS IN THIS COLUMN **<u>ONLY IF YOU DO *NOT* KEEP PRETTY REGULAR BEDTIME HOURS</u>**

| For times when your bedtime is *early:*

If there is a pattern by day of the week, describe:

On those early to bed days:

a. Your typical bedtime: __:__ AM PM
b. The *latest* time you might typically go to bed __:__ AM PM
c. The *earliest* time you might typically go to bed __:__ AM PM

d. Your typical time of awakening for the day __:__ AM PM
e. The *latest* you might wake for the day __:__ AM PM
f. The *earliest* you might wake for the day __:__ AM PM

| For times when your bedtime is *late:*

If there is a pattern by day of the week, describe:

On those late to bed days:

a. Your typical bedtime: __:__ AM PM
b. The *latest* time you might typically go to bed __:__ AM PM
c. The *earliest* time you might typically go to bed __:__ AM PM

d. Your typical time of awakening for the day __:__ AM PM
e. The *latest* you might wake for the day __:__ AM PM
f. The *earliest* you might wake for the day __:__ AM PM

Please add below anything else that pertains to any regularities or variability in when you go to sleep and when you wake up:

2. If you work, go to school, have other have other responsibilities or regular activities during the day, please also answer the following or write *non-applicable*:

   What is your usual daily schedule[1]:

   a. Usual time leaving the house for the day: ______
   b. Time when you arrive at (work, school, other): _______
   c. Times when you eat:

      breakfast _____ supper _____

      lunch _____ snacks _____

   d. Please note the general tenor of the days, e.g. stressful, pleasant, etc.

   e. Indicate the primary changes in schedule and how pleasant or unpleasant, stressful or unstressful, your day is on week-ends, holidays or other times when you do not go to work, to school, etc.

3. About your sleeping environment:

a. Disruptions

uncomfortable bed ___ Yes ___ No
disruptive bedpartner ___ Yes ___ No
pets in your room ___ Yes ___ No
street sounds ___ Yes ___ No
house noises ___ Yes ___ No
other ___ Yes ___ No

b. Your bed, mattress, bed clothes

standard (full) mattress ___ Yes ___No
twin mattress ___ Yes ___No
queen/king mattress ___ Yes ___No
waterbed ___ Yes ___No
futon ___ Yes ___No
more than 1 pillow ___Yes ___No
sleep on couch or recliner ___ Yes ___No
require lots of covers ___ Yes ___No
other:

[1] IF YOU DO NOT HAVE A TYPICAL SCHEDULE, OR IF YOUR SCHEDULE DIFFERS ON A DAILY BASIS, PLEASE INDICATE WHICH OF THESE IS SO. ALSO PLEASE DESCRIBE THE KINDS OF ROUTINE DAILY ACTIVITIES YOU DO (FOR INSTANCE, STANDING ON AN ASSEMBLY LINE ALL DAY, SITTING IN FRONT OF A COMPUTER MOST OF THE DAY, BEING ON THE ROAD A GREAT DEAL DRIVING A CAR FROM ONE PLACE TO ANOTHER, ETC.

4. Good sleeping position for you:

On your back ___ Yes ___No
On your side ___ Yes ___No
On your stomach ___ Yes ___No
In fetal position ___ Yes ___No
Other:

5. Difficult sleeping position for you:

On your back ___ Yes ___No
On your side ___ Yes ___No
On your stomach ___ Yes ___No
In fetal position ___ Yes ___No
Other:

6. Places/situations where you can sleep soundly:

Anywhere ___ Yes ___No
My own bed, light OFF ___ Yes ___No
My own bed, light ON ___ Yes ___No
Away from my own bedroom ___ Yes ___No
Watching TV ___ Yes ___No
While reading ___ Yes ___No
Listening to the radio ___ Yes ___No

7. Places/situations where you cannot sleep soundly:

Anywhere ___ Yes ___No
My own bed, light OFF ___ Yes ___No
My own bed, light ON ___ Yes ___No
Away from my own bedroom ___ Yes ___No
Watching TV ___ Yes ___No
While reading ___ Yes ___No
Listening to the radio ___ Yes ___No

8. Times when you sleep most soundly:

Pretty much the same most of the time ___ Yes ___No
Days when I go to work or school ___ Yes ___No
Non-holiday and non-work/non-school days ___ Yes ___No
Holidays or vacations ___ Yes ___No
Other (please describe):

❖: HEALTH HABITS

1. About how much alcohol (e.g. number of cans of beer, ounces of scotch, etc.) do you drink:

Alcohol Type (Beer, wine, hard liquor, etc.)	Unit Measurement (cans, glasses, shots, etc.)	Quantity per unit time (a 6-pack per week, bottle of wine every couple of weeks, etc.)

If you drank alcohol in the past, please indicate how much and when (*if none, please indicate none*): ______________________________

Did you ever have, or do you currently have, an alcohol addiction?

If your answer is yes, are you involved with:

Alcoholics Anonymous (AA)?

Al-Anon?

Alateen?

Other 12-step program?

2. How much coffee, tea, chocolate, caffeinated soft drinks, do you drink or eat daily? If none, please state none. Please note, diet soft drinks are not necessarily decaffeinated.

Caffeine Type (Cafffeinated coffee, decaf coffee, tea, cocoa, etc.)	Unit Measurement (cups, pots, glasses, 12 oz cans, etc.)	Quantity per unit time (24 fluid ozs/day, two cups in the morning, 3 12 oz mugs/day, etc.)

If you have recently stopped using caffeine products, please indicate how much caffeine you had been using, approximate amount of time you were using caffeine, and when you stopped using the caffeine.

3. How many packs of cigarettes do you smoke daily, on the average? Also indicate how long you have been smoking. If none, please state none:

   Packs per day: ______________

   Length of time smoking: ________________

   If you smoked in the past, how many packs/day did you smoke then? (If none, please state none) _____________

   If you did smoke, when did you stop. _________________

   How long had you been smoking? _________________

4. How much exercise do you get daily (if none, please state none):

   Type of exercise: ____

   How much exercise/day or week: ________________________________

5. Do you have any weight, over-eating or under-eating problems? If none, please state none. If you do, please provide some detail.

6. What is your current height? _______ Weight? _____. If this is a change from in the past, please provide details:

7. Nutrition. Please describe the kinds of food you tend to eat for:

   breakfast: snacks:
   lunch: liquids:
   supper: supplements:

❖. STRESS

1. Please list the current stressors in your life:

2. How do you deal with stress, and how successful/unsuccessful your coping strategy is in actually alleviating the stress:

3. For those times when your coping strategy was not particularly successful, describe how you feel (e.g. headache, runaway thoughts, tension in head/neck/shoulders, poor sleep, irritable, etc.) when you DO feel stressed out:

4. When your standard coping strategies DON'T work, what are the second-line things you might do (e.g. talk to a friend, scream into a pillow, take a tranquilizer or other medication, write lists, etc.).

5. Please identify any other aspects of how you live your life or things you actually do which might have either positive or negative influence on your health:

Symptom Check List about Mood

0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely

This questionnaire should be completed at the end of the day, close to bedtime. It is a list of words that describes feelings people have. Please read each description carefully. Then BLACKEN IN the space to the right of the description, corresponding to how much of the feeling you have AT THE END OF THE DAY. The scale to the right explains what each number means.

	0	1	2	3	4
1. Friendly	☐	☐	☐	☐	☐
2. Tense	☐	☐	☐	☐	☐
3. Angry	☐	☐	☐	☐	☐
4. Worn out	☐	☐	☐	☐	☐
5. Unhappy	☐	☐	☐	☐	☐
6. Clear-headed	☐	☐	☐	☐	☐
7. Lively	☐	☐	☐	☐	☐
8. Confused	☐	☐	☐	☐	☐
9. Sorry for things done	☐	☐	☐	☐	☐
10. Shaky	☐	☐	☐	☐	☐
11. Listless	☐	☐	☐	☐	☐
12. Peeved	☐	☐	☐	☐	☐
13. Considerate	☐	☐	☐	☐	☐
14. Sad	☐	☐	☐	☐	☐
15. Active	☐	☐	☐	☐	☐
16. On edge	☐	☐	☐	☐	☐
17. Grouchy	☐	☐	☐	☐	☐
18. Blue	☐	☐	☐	☐	☐
19. Energetic	☐	☐	☐	☐	☐
20. Panicky	☐	☐	☐	☐	☐
21. Hopeless	☐	☐	☐	☐	☐
22. Relaxed	☐	☐	☐	☐	☐
23. Unworthy	☐	☐	☐	☐	☐
24. Spiteful	☐	☐	☐	☐	☐
25. Sympathetic	☐	☐	☐	☐	☐
26. Uneasy	☐	☐	☐	☐	☐
27. Restless	☐	☐	☐	☐	☐
28. Unable to Concentrate	☐	☐	☐	☐	☐
29. Fatigued	☐	☐	☐	☐	☐
30. Helpful	☐	☐	☐	☐	☐
31. Annoyed	☐	☐	☐	☐	☐
32. Discouraged	☐	☐	☐	☐	☐
33. Resentful	☐	☐	☐	☐	☐
34. Nervous	☐	☐	☐	☐	☐
35. Lonely	☐	☐	☐	☐	☐
36. Miserable	☐	☐	☐	☐	☐
37. Muddled	☐	☐	☐	☐	☐
38. Cheerful	☐	☐	☐	☐	☐
39. Bitter	☐	☐	☐	☐	☐
40. Exhausted	☐	☐	☐	☐	☐
41. Anxious	☐	☐	☐	☐	☐
42. Ready to fight	☐	☐	☐	☐	☐
43. Good natured	☐	☐	☐	☐	☐
44. Gloomy	☐	☐	☐	☐	☐
45. Desperate	☐	☐	☐	☐	☐
46. Sluggish	☐	☐	☐	☐	☐
47. Rebellious	☐	☐	☐	☐	☐
48. Helpless	☐	☐	☐	☐	☐
49. Weary	☐	☐	☐	☐	☐
50. Bewildered	☐	☐	☐	☐	☐
51. Alert	☐	☐	☐	☐	☐
52. Deceived	☐	☐	☐	☐	☐
53. Furious	☐	☐	☐	☐	☐
54. Efficient	☐	☐	☐	☐	☐
55. Trusting	☐	☐	☐	☐	☐
56. Full of pep	☐	☐	☐	☐	☐
57. Bad tempered	☐	☐	☐	☐	☐
58. Worthless	☐	☐	☐	☐	☐
59. Forgetful	☐	☐	☐	☐	☐
60. Carefree	☐	☐	☐	☐	☐
61. Terrified	☐	☐	☐	☐	☐
62. Guilty	☐	☐	☐	☐	☐
63. Vigorous	☐	☐	☐	☐	☐
64. Uncertain about things	☐	☐	☐	☐	☐
65. Bushed	☐	☐	☐	☐	☐

Make sure you've answered every

Please check the appropriate box for each statement about yourself:

	None of the time	A little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel down-hearted, blue and sad					
2. Morning is when I feel the best					
3. I have crying spells/feel like it					
4. I have trouble sleeping through the night					
5. I eat as much as I used to					
6. I enjoy looking at, talking to and being with attractive people					
7. I notice I am losing weight					
8. I have trouble with constipation					
9. My heart beats faster than usual					
10. I get tired for no reason					
11. My mind is as clear as it used to be					
12. I find it easy to do things					
13. I am restless and can't keep still					
14. I feel hopeful about the future					
15. I am fairly irritable					
16. I find it easy to make decisions					
17. I feel that I am useful and needed					
18. My life is pretty full					
19. I feel others would be better off if I were dead					
20. I still enjoy things as I did in years past					

C. PERSONAL AND FAMILY MEDICAL HISTORY

YOUR DOCTOR WILL PROVIDE US WITH AS MUCH MEDICAL INFORMATION AS HE OR SHE HAS IF YOU REQUEST HER OR HIM TO SEND THIS INFORMATION TO US. HOWEVER, SINCE SO MANY OF US EITHER SEE A DOCTOR INFREQUENTLY, SEE DIFFERENT DOCTORS FOR DIFFERENT PROBLEMS, ETC., IT IS POSSIBLE THAT NO ONE OF YOUR HEALTH CARE PROVIDERS HAS ALL RELEVANT INFORMATION. WE WOULD THEREFORE APPRECIATE YOUR ANSWERING THESE QUESTIONS YOURSELF.

1. Please check all illnesses, injuries, medical conditions which you have had and indicate approximate dates:

MEDICAL CONDITION	DATE OF ONSET/OFFSET	ASSOCIATED MEDICATIONS, TREATMENT
___ High Blood pressure		
___ Heart Attack		
___ Angina		
___ Other Heart Problems (specify)		
___ Allergies (Please specify type)		
___ Nose Injury		
___ Asthma		
___ Emphysema		
___ Other lung problems (please specify)		
___ Gout		
___ Thyroid problems		

MEDICAL CONDITION	DATE OF ONSET/OFFSET	ASSOCIATED MEDICATIONS, TREATMENT
____ Diabetes		
____ Hypoglycemia		
____ Arthritis		
____ Epilepsy		
____ Migraine headaches		
____ Tension headaches		
____ Ulcers		
___ Other digestive problems (specify)		
___ Other (specify)		
___ Other (specify)		
___ Other (specify)		

2. Please list ALL medicines, other than those which you have already mentioned above which you *currently* take on a regular OR occasional basis. Include prescription and non-prescription (e.g. aspirin, Tylenol) drugs. If you are using birth control pills, please note this as well.

MEDICATION	PURPOSE FOR TAKING IT	DOSAGE	WHO PRE-SCRIBED?	DATE BEGAN

3. Now, please list all medications which you are *not* currently taking, but which you have taken on a regular basis in the past. Please indicate approximately how long you were using the drug, and about when you stopped taking it.

MEDICATION	HOW LONG USED	DATE STOPPED

If you have not included recreational drugs above, please also list any recreational drugs you have used, approximate dates when you used each drug, and approximate frequency of use of each drug.

4. Did you ever take any more of any of the above drugs or medications than was prescribed, or did anyone ever suggest that you were addicted to any of these? If so, please describe.

5. Please indicate any surgery you have had. Please provide approximate dates:

SURGERY	APPROXIMATE DATES

6. If you have been hospitalized for any other reasons (i.e. other than for surgeries), please provide description/purpose of hospitalizations and approximate dates. Please include psychiatric hospitalizations, if relevant, in this section.

DESCRIPTION/ PURPOSE OF HOSPITALIZATION	APPROXIMATE DATES
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

7. Please list any special medical tests (like an electro-cardiogram for heart function, EEG because of a question of epilepsy or other nervous system problem, pulmonary function test because of a possible lung problem, etc.) you have had in the past ten years. Note also the reason for the test and the results if you have that information available.

TEST	APPROXIMATE DATE	PURPOSE OF TEST	RESULTS

8. Have you reached menopause (the change?) YES__ NO__ N/A __
   If so, when?_______

9. Have you had seizures (fits) in the past/do you have a current seizure disorder? Please describe.

10. Have you had one or more head injuries? __________

11. Have you lost consciousness? _____ If so, please describe the circumstances.

    Was follow-up evaluation such as with a neurologist necessary?_____
    Please provide additional information.

12. Do you wear dentures? ________ If so, do you wear an upper plate?_______ For how many years? ________ Do you wear them when you go to sleep? ________

13. Do you wear any kind of dental appliance:

    during the daytime: ___ yes ___ No
    during the nighttime: ___ yes ___ No

Please describe anything about your medical history you have not been asked about, but which you think might be important or pertinent to your current problem.

PERTINENT FAMILY HISTORY

1. Please list biological family members (including grandparents, parents, siblings, children) who have difficulty either with snoring, with their sleep, or with staying awake during the day; or who have a sleep or wakefulness problem similar to yours:

Relationship of Family Member to You	Type of sleep/wake related problem

2. Please list biological family members (including grandparents, parents, siblings, children) who have had an illness which required sustained treatment (e.g. heart disease, high blood pressure, stroke, diabetes, thyroid problems); problems with alcohol or drug abuse; problems with chronic depression, anxiety, other psychiatric illness. Please specify each condition and the relationship of the person to you.

Relationship of Family Member to You	Type of Medical/Alcohol/Psychiatric/ Etc. Problem