ALL ABOUT YOUR SLEEP

1. **How long** has your difficulty with sleeping been a problem?

   _____

2. What time do you:

   a. Go to **bed** on weekdays? _____ Weekends? _____

   b. Fall **asleep** on weekdays? _____ Weekends? _____

   c. **Wake up** on weekdays? _____ Weekends? _____

3. How many times do you wake up during the night and why?

   _____

4. Do you: (please mark with X)

	Never	Rarely	Sometimes	Often	Always
a. **Snore**?					
b. Have **Breathing** difficulties or **choking** during sleep?					
c. Have **uncomfortable leg sensations** (eg. Feeling Restless, crawling, tension)?					
d. **Jumpy or jerky legs** during sleep?					
e. **Sleep walk** or **odd behaviour** during sleep?					
f. Have **reflux** or **indigestion**?					
g. Take **sleeping tablets**/herbals?					
h. Have panic/**anxiety** attacks:					
i. Sleep much better during a **vacation** or different environment?					

5. During the last month have you often felt:

	Never	Rarely	Sometimes	Often	Always
a. Troubled by feeling down, **depressed** or hopeless?					
b. Troubled by **little interest/pleasure** in doing things?					
c. Daytime sleepiness					

6. Do you have difficulties with:

	Never	Rarely	Sometimes	Often	Always
a. Concentration					
b. Memory					
c. Daytime sleepiness					

7. What treatments have you had to try and help?

   _____

8. How much **coffee or tea** do you consume in the day & at what times?

   _____

9. How much **alcohol** to you consume and when?

   _____

Please list all **medical conditions** you have:

_____

_____

_____

ALL ABOUT YOUR SLEEP

Please list your current **medications**:

MEDICATION	DOSE	TIMES A DAY	MEDICATION	DOSE	TIMES A DAY

Do you have any **allergies**? Yes ☐ No ☐

If yes please list (including food, drugs, lotions, latex) & include the type of reaction:

_____

_____

Have you every **smoked**? Yes ☐ No ☐

If yes:

Age started? _____ Age stopped? _____ How many a day? _____

DAYTIME SLEEPINESS

Please tick any of the following statements that are true for you.

I have sometimes fallen asleep at very inappropriate times, such as whilst driving, eating or during a conversation.	
I have sometimes been so sleepy that I became confused or lost track of the topic during a conversation.	
I am frequently so sleepy during the day that my work is poor.	
I have had accidents or near-accidents when driving because I felt so sleepy.	
When I have no plans or appointments the next day, I frequently go to bed late (compared with my usual bedtime).	
I frequently do not feel sleepy at bedtime and stay up until it is late so that as a consequence I get too little sleep.	

MODIFIED SLEEPMED INSOMNIA INDEX

This is a test to assess, in general, how you are feeling about your sleep.
Answer the following questions rating how you feel about your sleep using a 0–4 point scale:

0 = No problem

1 = Slight problem

2 = Moderate problem

3 = Moderately severe problem

4 = Severe problem, affecting all parts of my life

SCORE

I have trouble falling asleep at night.	0
When I do not sleep, I worry about it the next day.	0
When I wake up during the night, I have trouble going back to sleep.	0
I wake up in the morning long before I have to.	0
Some nights, I never get to sleep no matter how hard I try.	2
When I try to go to sleep, my mind races with many thoughts.	2
At night when I go to bed I do not feel sleepy.	2
I often sleep better in an unfamiliar bedroom, such as a hotel or motel room.	2
When I try to fall asleep, I become anxious or nervous.	2
When I try to fall asleep, I worry about whether or not I can sleep.	2
When I try to fall asleep, I often feel hungry or thirsty.	2
When I try to sleep I feel pain.	2
Pain often wakes me up or keeps me from going back to sleep.	2
I have a creeping, crawling sensation in my legs when I lie down to sleep.	2
When I do sleep, I feel that I sleep very well.	2
I am a very light sleeper. I am easily awakened by noises.	2
My sleep is disturbed because of my bed partner.	2
Heat or cold disturbs my sleep.	2
Generally I get up in the middle of the night for a snack.	2