National Jewish Health
Science Transforming Life®

Sleep Center

Main Campus
1400 Jackson Street
Denver, CO 80206

Highlands Ranch Location
8671 S. Quebec St., Ste. 120
Highlands Ranch, CO 80130

DTC Location
7877 South Chester St.
Englewood, CO 80112

#1 respiratory hospital in the U.S.
US News & World Report

INSOMNIA CLINIC SLEEP HISTORY QUESTIONNAIRE

PRIOR TO SCHEDULING:

1. A referral with a diagnosis of **Insomnia** from patient's physician must be sent to National Jewish Health Sleep Center, regardless of insurance.
2. Patient to submit completed questionnaire. Email: CenterS@njhealth.org or fax (303) 270-2109
3. If required by patient's insurance, an authorization needs to be sent to National Jewish Health Sleep Center.

PART I: IDENTIFYING INFORMATION

Name:_____Date: _____

Phone:_____ Home Mobile Work (circle one)

Street Address:_____City/State_____

Age:_____Date of Birth:_____ Sex: Female Male (circle one)

Education (years of school):_____Occupation: _____

Marital Status:_____Years:_____

# of Children: _____

PART II: SLEEP HISTORY

1. Please describe your sleep problem.

_____

_____

2. Estimate how many hours of sleep you get…

a) on a good night_____ b) on a bad night_____

3. How long does it take you to fall asleep…

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

4. How many times do you wake up during the night…

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

5. How long are you awake during the night after initially falling asleep…

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

6. How long have you had this problem? _____

7. Has it increased in severity, and if s

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

_____

9. Did you have sleep problems as a child? Yes No (circle one)

10. Please describe the problem(s).____

_____

PART III: DAYTIME FUNCTIONING

1. Do you have a problem with severe sleepiness (feeling very sleepy or struggling to stay awake during the daytime?

   Yes No (circle one)

   If yes, how many days during the average week? _____

2. Do you often have a problem with your performance at work or school because of sleepiness?

   Yes No (circle one)

3. Have you ever had car accidents because of sleepiness (not due to alcohol or drugs)?

   Yes No (circle one)

4. Have you ever had near car accidents (for example, driving off of the road) because of sleepiness (not due to alcohol or drugs)?

   Yes No (circle one)

5. Do you fall asleep without meaning to during the day?

   Yes No (circle one)

   If yes, how many times during the average week? _____

6. How many naps do you take during the average week? _____

   How long is your average nap? _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose 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**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

PART IV: BEDTIME CHARACTERISTICS

1. On average, what is your normal bedtime? _____
2. On average, what time do you get out of bed in the morning? _____
3. Do you have a standard wake-up time that you use?:

   7 days per week? Yes No 5 days per week? Yes No
4. Does your job require that you change shifts? Yes No (circle one)
5. How often do you travel across time zones?_____times per month
6. Do you have a bed partner? Yes No (circle one)

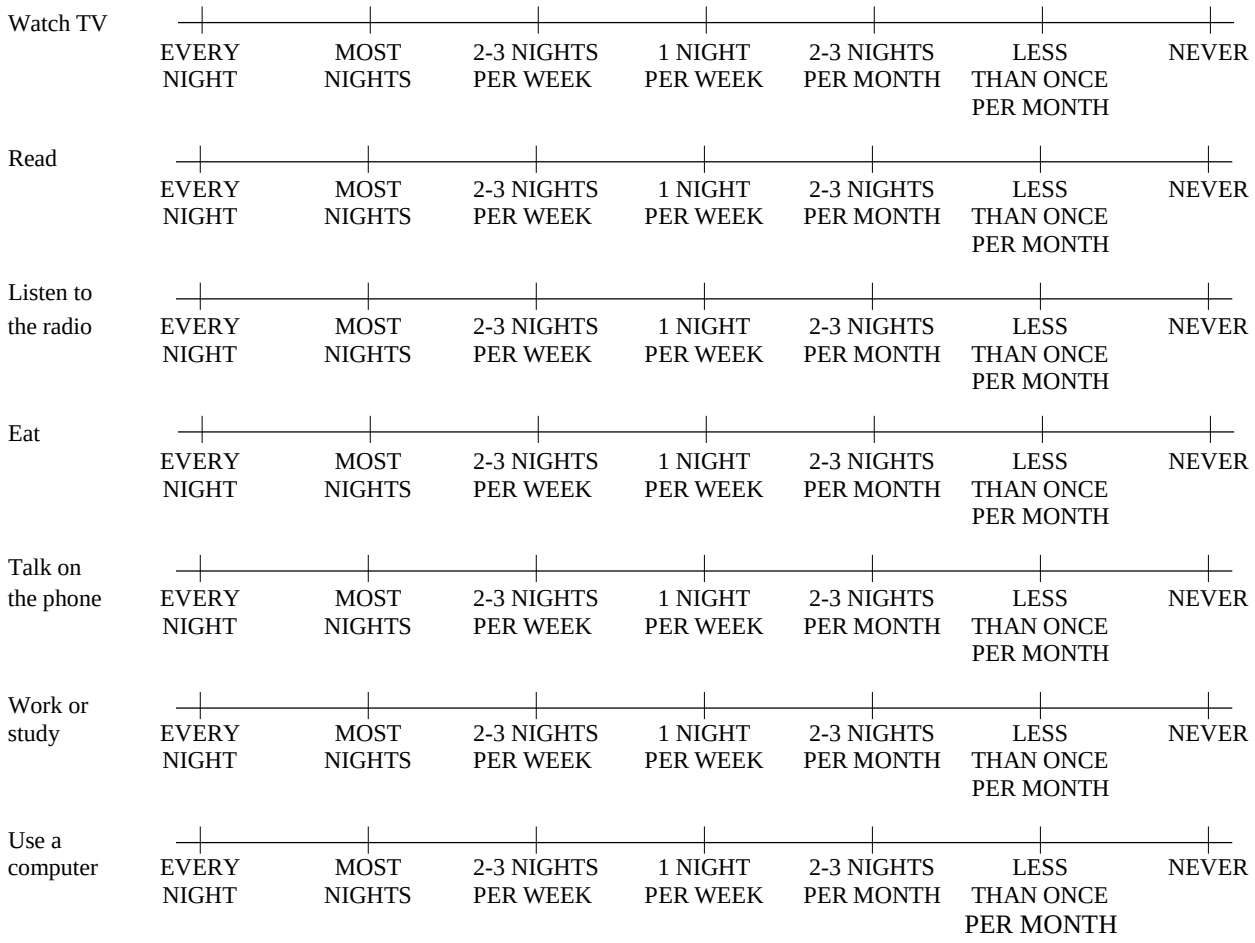
   If yes, does your bed partner do anything that interferes with your sleep?
   Yes No (circle one)
   If yes, please describe: _____

   _____

   _____

ACTIVITIES DURING THE NIGHT

Do you ever engage in any of these activities while in bed during the night?
Circle the *most appropriate answer*.



1. Please **circle a number** from 1 to 10 to indicate how much difficulty you have relaxing your body at bedtime.

   no difficulty some difficulty great difficulty

   1 2 3 4 5 6 7 8 9 10

2. Please **circle a number** from 1 to 10 to indicate how much difficulty you have "slowing down" or "turning off" your mind while trying to sleep.

   no difficulty some difficulty great difficulty

   1 2 3 4 5 6 7 8 9 10

PART V: ADDITIONAL SLEEP COMPLAINTS (indicate yes or no by checking the appropriate box):

	YES	NO
Excessive daytime sleepiness	☐	☐
Inability to move while awake in bed	☐	☐
Loss of muscle tone or paralysis when you laugh or are angry	☐	☐
See disturbing or frightening images while awake in bed	☐	☐
Frequent snoring	☐	☐
Apneas (breath holding during sleep)	☐	☐
Wake up gasping, choking or feeling short of breath	☐	☐
Excessive sweating during sleep	☐	☐
Headaches on awakening	☐	☐
Nighttime heartburn	☐	☐
Frequent strong urges to move your legs	☐	☐
Unpleasant sensations in your legs at night or at bedtime	☐	☐
Twitching or jerking of your legs during sleep	☐	☐
Unusual movements or behavior during sleep	☐	☐
Frequent disturbing dreams or nightmares	☐	☐
Sleepwalking	☐	☐
Acting out your dreams	☐	☐
Teeth grinding or clenching	☐	☐

PART VI: MEDICATION HISTORY

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

2. Currently, how much alcohol do you use to help you sleep?
   _____amount per night_____ times per month

3. Please list all medications, prescribed and over-the-counter, you are presently taking or have recently stopped taking and the reason for taking these medications
   (use back of page if necessary or attach current list to this questionnaire).

Medication	Dosage/times per day	Reason	Current (yes/no?)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

4. Do you consume any of the following?

   Caffeinated coffee: ☐ Yes ☐ No

   If yes, how much:_____per day

   Caffeinated tea: ☐ Yes ☐ No

   If yes, how much:_____per day

   Caffeinated soda: ☐ Yes ☐ No

   If yes, how much:_____per day

   Smoking: ☐ Yes ☐ Quit ☐ Never

   If yes, how much:_____per day

   Alcohol use: ☐ Yes ☐ No

   If yes, how much:_____per day

   Recreational drugs: ☐ Yes ☐ No

   If yes, how much:_____per day

5. Do you exercise: ☐ Yes ☐ No

   If yes, how much:_____per day

6. Describe any other treatments you have had for your sleep problem and how well these previous treatments worked.

_____

_____

PART VII: GENERAL MEDICAL HISTORY

1. Please check (√) in the boxes beside those medical problems you have now or have had in the past.

√	PROBLEM	√	PROBLEM	√	PROBLEM
	Arthritis		Asthma		Chronic pain
	Depression		Diabetes		Memory/Concentration Problems
	Emphysema/COPD		Epilepsy		Headaches
	Heartburn/Ulcers		High Blood Pressure		Hallucinations/Delusions
	Kidney Problems		Hiatal Hernia		Childhood Hyperactivity
	Panic Attacks		Nose/Throat Problems		Alcohol/Drug Problems
	Sexual Problems		Anxiety/Nervousness		Loss of Sex Drive
	Stroke		Suicide Attempts		Swelling Ankles
	Thyroid Problems		Cold/Heat Intolerance		Trouble Breathing at Night
	Changes in Hair or Skin				

Other Medical Problems/list here_____

_____

_____

2. Have you ever been treated by a psychiatrist, psychologist, or other mental health professional?
   Yes No (circle one)

   If yes, please indicate where and when you were treated and for what reason.

   _____

   _____

   _____

   _____

3. Have you ever had your sleep recorded in a sleep laboratory or in your home?
   Yes No (circle one)

   If yes, please give details and describe the results of the recording(s) if you are aware of them.

   _____

   _____

   _____

PART VIII: OTHER INFORMATION

In the spaces provided below, please add any information that you feel is important.

_____

_____

_____

_____

_____

INSOMNIA SEVERITY INDEX

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

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

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

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

6. How WORRIED/DISTRESSED are you about your current sleep problem?

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

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

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