#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. 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…
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 so...

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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. a theater or a meeting)</td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
<td></td>
</tr>
</tbody>
</table>

**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?  
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.

<table>
<thead>
<tr>
<th>Activity</th>
<th>EVERY NIGHT</th>
<th>MOST NIGHTS</th>
<th>2-3 NIGHTS PER WEEK</th>
<th>1 NIGHT PER WEEK</th>
<th>2-3 NIGHTS PER MONTH</th>
<th>LESS THAN ONCE PER MONTH</th>
<th>NEVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watch TV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listen to the radio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk on the phone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work or study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use a computer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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):

- 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).

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage/times per day</th>
<th>Reason</th>
<th>Current (yes/no?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

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

<table>
<thead>
<tr>
<th>Insomnia Problem</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty falling asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Difficulty staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Problems waking up too early</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

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