



Sleep Center

Main Campus
1400 Jackson Street
Denver, CO 80206

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

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

DTC Location
7877 South Chester St.
Englewood, CO 80112

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...

- 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 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

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: _____
 - _____
 - _____

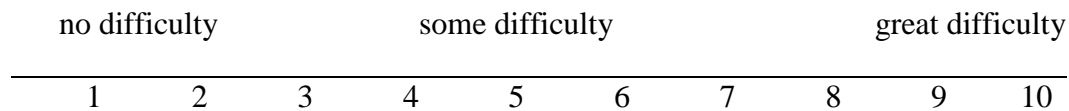
ACTIVITIES DURING THE NIGHT

Do you ever engage in any of these activities while in bed during the night?

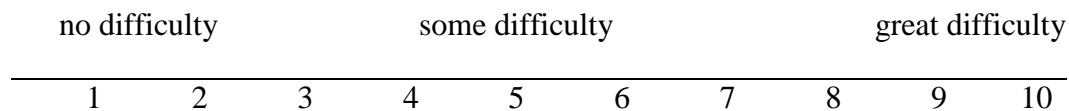
Circle the *most appropriate answer*.

Watch TV	_____						
	EVERY NIGHT	MOST NIGHTS	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN ONCE PER MONTH	NEVER
Read	_____						
	EVERY NIGHT	MOST NIGHTS	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN ONCE PER MONTH	NEVER
Listen to the radio	_____						
	EVERY NIGHT	MOST NIGHTS	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN ONCE PER MONTH	NEVER
Eat	_____						
	EVERY NIGHT	MOST NIGHTS	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN ONCE PER MONTH	NEVER
Talk on the phone	_____						
	EVERY NIGHT	MOST NIGHTS	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN ONCE PER MONTH	NEVER
Work or study	----- ----- ----- ----- ----- ----- ----- -----						
	EVERY NIGHT	MOST NIGHTS	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN ONCE PER MONTH	NEVER
Use a computer	----- ----- ----- ----- ----- ----- ----- -----						
	EVERY NIGHT	MOST NIGHTS	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN ONCE PER MONTH	NEVER

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



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.



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

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

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).

	<u>Medication</u>	<u>Dosage/times per day</u>	<u>Reason</u>	<u>Current (yes/no?)</u>
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