Please complete front and back of form

Date		Review date		Review date
Name			Date of birth	Age
Height	Weight now	Weight 1 yr ago		Gender: (circle one) MALE FEMALE
Occupation			Employer	
Shift worker? YES NO If yes, please describe:				
How did you first hear of CU Sleep? PHYSICIAN TV RADIO SEMINAR NEWSPAPER INTERNET FRIEND OTHER				
Referring physician			City	
Regular doctor			City	
Has your address, telephone number, or insurance changed recently? YES NO If so, please put latest information here:				

Sleep habits	Work days	"Weekends"
Bedtime		
Arise time		
Hours of sleep (don't count in bed awake)		
How many minutes it takes to fall asleep		
Usually take how many naps?		

What is your main sleep problem?_____

_____

_____

When did this problem begin? _____

_____

Is the problem … INCREASING DECREASING STAYING SAME

How much do you want to fix this problem?
MUST FIX WOULD **LIKE** TO FIX NOT VERY IMPORTANT

Amount of sleep you need to feel well rested: _____ hours

If you take naps, what is the usual length? _____ minutes

How long it takes you to fully wake up: _____ minutes

Do you find naps refreshing? YES NO

Does your sleep problem affect (circle all that apply):
WORK HOME LIFE RELATIONSHIPS SAFETY

Do any of your sleep problems seem to go in cycles? YES NO If yes, describe:

Epworth Sleepiness Scale

How likely are you to actually doze off or fall asleep in the following situations, in contrast to feeling just tired? 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

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 in the afternoon
when circumstances permit……..…… _____

Sitting and talking with someone……. _____

Sitting quietly after a lunch
without alcohol……. _____

In a car, while stopped for a few
minutes in traffic…….. __ _____

TOTAL _____

Symptoms Check off how frequently you have experienced the items below (in the past 3 - 6 months):	Always	Frequently	Occasionally	Never
Snoring				
Gasping, choking, or short of breath during sleep				
Coughing disrupting sleep				
Awaken with dry mouth				
Wake up with a headache				
Sinus trouble/congestion disrupting sleep				
Difficulty breathing in a flat position				
Others see pauses in my breathing during sleep				
Fall asleep unintentionally				
Feel sleepy during the daytime				
Feeling paralyzed in bed				
Muscle weakness when emotional				
See dreamlike images when not fully asleep				
Wake up and can't get back to sleep				
Unable to fall asleep quickly enough				
Mind races when I try to sleep				
Anxiety or depression				
Tossing and turning				
Urge to walk / move legs when at rest				
Uncomfortable sensations in limbs at rest				
Leg or body jerks				
Sleep walking				
Bed-wetting				
Head-banging or body rocking				
Frightening dreams				
Acting out dreams/nightmares				
Waking up screaming, violent, or confused				
Night sweats				
Teeth-grinding during sleep				
Sleep with another person in the bed				
Sleep with a pet in the bed				
Get up to attend to others at night				
Sleep disturbed by light, noise, or temperature				
Sleep disrupted by urgent need to urinate				
Sleep disrupted by hunger or thirst				
Wake up gagging OR with a sour taste in mouth OR burning throat				
Sleep disrupted by pain or physical discomfort (please describe): _____				