Sleep Disorders Clinic - New Patient Intake Form

NAME: DATE OF BIRTH:

- ☐ Have difficulty falling asleep.
- ☐ Have difficulty maintaining sleep.
- ☐ Have difficulty falling *back* to sleep
- ☐ Other complain about snoring.
- ☐ Others notice you stop breathing.
- ☐ Feel sleepy even after a good night's sleep.
- ☐ Fallen asleep while driving.
- ☐ Weight gain in the past year.
- ☐ Difficulty breathing through nose.
- ☐ Wake up with headaches.
- ☐ Wake with dry mouth.
- ☐ Grind teeth when asleep.
- ☐ Wake with pounding or fast heartbeat.
- ☐ Wake up gasping.
- ☐ Middle of the night urination.
- ☐ Heartburn that wakes you up.
- ☐ Pain that disturbs your sleep.
- ☐ Racing thoughts at night.
- ☐ Nightmares.
- ☐ Irritability.
- ☐ Difficulty concentrating.
- ☐ Wake up completely paralyzed.
- ☐ Muscles go limp *when* laughing, surprised, ☐ excited, afraid, or angry.
- ☐ Legs are restless when sitting or lying down.
- ☐ Kick legs while asleep.
- ☐ Walk, talk, eat when asleep.
- ☐ Night sweats.

Prior sleep studies:

Family history of any sleep disorders such as:
☐ Sleep apnea ☐ Restless legs ☐ Narcolepsy

☐ Active-duty ☐ Dependent ☐ Retiree

Occupation / MOS:_____

In next 12 months, will you:
☐ Deploy ☐ PCS ☐ ETS ☐ Retire ☐ MEB

Marital status:_____

How many alcohol drinks per week?_____

How much caffeine do you drink daily?_____

Use Pre-Workout? _____

What tobacco products do you use?_____

SLEEP SCHEDULE	**WEEKDAYS**	**WEEKENDS**
What time do you get into bed?		
When is the last time you get out of bed to start your day?		
Estimated number of hours you sleep per night		
Number and length of naps		
How long does it take you to fall asleep in the beginning of the night?		
Number of awakenings per night		
How long does it take you to fall back asleep?		

EPWORTH SLEEPINESS SCALE	
How likely are you to nod 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 haven't 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 = no chance of dozing** **1 = slight chance of dozing** **2 = moderate chance of dozing** **3 = high 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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
ADD UP THE TOTAL	

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