SLEEP HABITS QUESTIONNAIRE

Name: _____ DOB: _____

Briefly describe your sleep problem and then answer the following questions about your sleep (what kind of problem, when it started, and how often your sleep/wake problem occurs): _____
_____
_____
_____

Do you have difficulty sleeping during the night? Circle: YES NO

If you answered YES, please answer the following questions.
If you answered NO, please answer questions #3 through #17.

1. How many nights per week on average have you been troubled by disturbed sleep? _____
   _____
   _____

   For how many years has this occurred? _____

2. Four common complaints about sleep are:
   a. Trouble getting to sleep
   b. Awakenings during the night
   c. Awakenings towards the morning and unable to go back to sleep
   d. Sleepiness during the day

   Please rate these problems on a 1-5 scale by circling the appropriate number:

1 = Not a Problem	***5 = Major Difficulty***				
Trouble getting to sleep	1	2	3	4	5
Awakenings during the night	1	2	3	4	5
Awakenings towards the morning and unable to go back to sleep	1	2	3	4	5
Sleepiness during the day	1	2	3	4	5

3. Do you think you feel excessively sleepy during the day? Circle: YES NO
4. What time do you usually go to bed? Weekdays: _____ Weekends: _____
5. What time do you typically wake up? Weekdays: _____ Weekends: _____
6. Do you usually feel refreshed in the morning? Circle: YES NO
7. How long does it take you to go to sleep (in minutes)? _____
8. How many hours per night do you think you sleep on average? _____

9. To wake up in the morning, do you use an alarm clock? Circle:
   Weekdays: YES NO
   Weekends: YES NO
10. Have you ever taken prescription or over the counter sleeping pills? Circle: YES NO
11. How do you sleep away from home? Circle: SAME BETTER WORSE
12. Do you fall asleep when you are not trying to? Circle: YES NO
    If yes, please describe examples: _____
    _____
    _____
13. Characterize your normal sleep habits. What rituals do you have in preparing for bed? Do you awaken during the night? If so, what for and how many times? _____
    _____
    _____
14. Do you snore? Circle: YES NO
    If YES, how many nights per week do you snore? _____
15. Have you experienced weakness in any part of your body at times of extreme laughter, sadness, or excitement? Circe: YES NO
    If YES, please describe: _____
    _____
16. Have you experienced unusual sensations or feelings in your lower legs (such as "creepy crawling")? Circle: YES NO
17. Have you ever awakened paralyzed (aware of your surroundings but unable to move for a brief period)? Circle: YES NO
18. Have you ever eaten food, consumed alcohol, or smoked cigarettes without full awareness or control (i.e. semi-consciously or unconsciously) during sleep or during partial awakenings at night? Circle: YES NO
    If YES, please describe: _____
    _____
    _____
    _____
19. Have you ever had any of the following? Circle applicable:

    Sleep Walking Bedwetting Marked Insomnia Excessive sleepiness

20. Comments (please comment on any aspect of your sleep or sleep-awake cycle that you feel necessary): _____
    _____
    _____