SLEEP QUESTIONNAIRE Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

This form asks questions about your sleep and factors associated with sleep problems, such as diet and stress. Please complete each question as accurately as possible. If you have any concerns about a question, make a note on this questionnaire beside the question and we will be sure to address your concern. If you are not requesting help from our service for a sleep problem, please do not complete this questionnaire and contact one of our personnel immediately. Thank you.

**Section 1: Identifying Information**

**1. Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

**2. Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2b. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Gender**: \_\_\_Male \_\_\_Female **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **5.** **SSN** \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

**6. Marital Status:** \_\_\_Single **7. Education**: \_\_\_Less Than High School Diploma

 \_\_\_Married \_\_\_High School Diploma (or GED)

 \_\_\_Separated \_\_\_Some College (no degree)

 \_\_\_Divorced \_\_\_Two Year Degree (e.g. A.S.)

 \_\_\_College Degree (4+ years)

 \_\_\_Some graduate work, no degree

 \_\_\_Advanced Degree (e.g., M.S., Ph.D)

**8. Military Status**: \_\_\_Active Duty **9. Branch of Service**: \_\_\_Air Force

 \_\_\_Retired From Active Duty \_\_\_Army

 \_\_\_Dependent of Active Duty \_\_\_Navy

 \_\_\_Dependent of Retired Member \_\_\_Marines

 \_\_\_Other \_\_\_Other

**10. Name of Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10a. Age of Spouse:\_\_\_\_\_\_\_\_\_\_**

 **10b. Occupation of Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10c. Date of Marriage:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**11. In the space below, list your children’s names, ages, and sex**

**12. Active Duty Military Only: 12a. Rank: \_\_\_\_\_\_\_\_\_\_\_\_ 12b. Date of Separation: \_\_\_\_\_\_\_\_\_\_\_**

 **12c. Years of Service: \_\_\_\_ 12.d. Flight Status \_\_\_Yes \_\_\_No 12e. SCI/PRP: \_\_\_Yes \_\_\_No**

 **12f. Present Duty Assignment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **12g. Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12h. Duty Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 2: In your own words, describe the problem(s) which brings you to our service**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 3: Nature of Your Sleep-Wake Problem**

1. Please rate the current severity of your sleep problem(s):

 1a. Difficulty Falling Asleep \_\_\_No \_\_\_Mild \_\_\_Moderate \_\_\_Severe \_\_\_Very Severe

 1b. Difficulty Staying Asleep \_\_\_No \_\_\_Mild \_\_\_Moderate \_\_\_Severe \_\_\_Very Severe

 1c. Difficulty Waking Up Too Early \_\_\_No \_\_\_Mild \_\_\_Moderate \_\_\_Severe \_\_\_Very Severe

For questions 2 to 6, circle the number which corresponds to the answer you feel best fits your current sleep problem.

2. How satisfied/dissatisfied are you with your current sleep pattern?

Very Moderately Very

Satisfied Satisfied Dissatisfied

1 2 3 4 5

3. To what extent do you consider your sleep problem to INTERFERE with your daily functions (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not At All A Little Somewhat Much Very Much

1 2 3 4 5

4. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not At All A Little Somewhat Much Very Much

1 2 3 4 5

5. How CONCERNED are you about your current sleep problem?

Not At All A Little Somewhat Much Very Much

1 2 3 4 5

6. To what extent do you believe the following factors are contributing to your sleep problem?

 None Some Much

Cognitive disturbances (racing thoughts at night): 1 2 3 4 5

Somatic disturbances (muscular tension, pain): 1 2 3 4 5

Bad sleeping habits: 1 2 3 4 5

Natural aging process: 1 2 3 4 5

7. After a poor night’s sleep, which of the following problems do you experience on the next day. Check all those that apply

Daytime fatigue: \_\_\_Tired \_\_\_Exhausted \_\_\_Washed out \_\_\_Sleepy

Difficulty functioning: \_\_\_Performance impairment at work/daily chores

 \_\_\_Difficulty concentrating, \_\_\_Memory difficulty

Mood problems: \_\_\_Irritable \_\_\_Tense \_\_\_Nervous \_\_\_Groggy \_\_\_Depressed

 \_\_\_Anxious \_\_\_Grouchy \_\_\_Hostile \_\_\_Angry \_\_\_Confused

Physical Symptoms: \_\_\_Muscle aches/pains \_\_\_Light-headed \_\_\_Headache

 \_\_\_Heartburn \_\_\_Muscle tension

8. How many nights each week do you have a problem with falling asleep? \_\_\_\_\_ nights

9. How many nights each week do you have a problem with staying asleep? \_\_\_\_\_ nights

10. On a typical night (over the past month), how long does it take

 you to fall asleep after you go to bed and turn the lights off? \_\_\_\_ hours \_\_\_\_ minutes

11. On a typical night, how long do you spend awake in the middle

 of the night? (total for all awakenings) \_\_\_\_ hours \_\_\_\_ minutes

12. What wakes you up at night? (check all that apply) \_\_\_Pain \_\_\_Child \_\_\_Lights

 \_\_\_Spouse \_\_\_Hunger \_\_\_Worries

 \_\_\_Noise \_\_\_Dreams \_\_\_Temperature

 \_\_\_Going to Bathroom \_\_\_Unknown

**Section 4: Your Current Sleep-Wake Schedule**

1. What is your usual bedtime on weekdays? \_\_\_\_\_\_\_\_\_\_ o’clock PM AM (circle PM or AM)

2. At what time do you last wake up in the morning? \_\_\_\_\_\_\_\_\_\_ o’clock PM AM (circle PM or AM)

3. When do you actually get out of bed on weekdays? \_\_\_\_\_\_\_\_\_\_ o’clock PM AM (circle PM or AM)

4. Do you have the same sleep-wake schedule on weekends? \_\_\_Yes \_\_\_No

5. If your sleep schedule changes on weekends, describe the changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. How often do you take naps (including unintentional naps)? \_\_\_\_\_ days/week

7. Do you ever fall asleep in inappropriate places? \_\_\_Yes \_\_\_No

 7a. If yes to above, where? (check all that apply): \_\_\_Work \_\_\_Driving \_\_\_Class \_\_\_Interesting TV

 \_\_\_Movies \_\_\_Church/Synagogue

8. How many hours of sleep per night do you usually get? \_\_\_\_ hours \_\_\_\_ minutes

**Section 5: Medication Use, Diet, Exercise**

1. In the past 4 weeks have you used *any* sleeping medication? \_\_\_Yes \_\_\_No

 1a. If yes, which medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 1b. Was this medication prescribed, over-the-counter, or both? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 1c. How many nights each week do you use the medication? \_\_\_\_\_\_\_\_\_\_\_\_\_nights

 1d. When did you *first* use sleep medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 1e. When did you *last* use sleep medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. If you do not currently use sleep medication, have you ever used sleeping medication? \_\_\_Yes \_\_\_No

3. In the past 4 weeks, have you used alcohol as a sleep aid? \_\_\_Yes \_\_\_No

 3a. If yes, what type and how many ounces? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_

 3b. How many nights each week? \_\_\_\_\_nights

4. Have you ever (at any time) used alcohol as a sleep aid? \_\_\_Yes \_\_\_No

5. How many alcoholic beverages to you drink each day? \_\_\_\_\_\_beverages

 5a. If you drink alcohol, what do you typically drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5b. If you drink alcohol, how many drinks do you have after dinner? \_\_\_\_\_\_\_drinks

6. How many caffeinated beverages do you drink per day? \_\_\_\_\_\_\_\_\_beverages

7. What caffeinated beverages do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you ever eat/snack after awakening during the night? \_\_\_Yes \_\_\_No

9. Do you smoke cigarettes? \_\_\_Yes \_\_\_No

 9a. If Yes, how many cigarettes do you smoke after dinner? \_\_\_\_\_cigarettes

10. List all of the medications you currently take, the amount you take, and why you take them (list both prescribed and over-the-counter medications): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. How many times each week do you exercise, on average? \_\_\_\_\_times

 11a. How long do you exercise at each occasion, on average? \_\_\_\_\_\_hours \_\_\_\_\_minutes

 11b. What exercises do you typically do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 11c. Do you sometimes exercise close to bedtime? \_\_\_Yes \_\_\_No

**Section 6: Your Bedroom Environment**

1. Are you sleeping with a bed partner? \_\_\_Yes \_\_\_No

2. Is your mattress comfortable? \_\_\_Yes \_\_\_No

3. Is your bedroom quiet? \_\_\_Yes \_\_\_No

4. Do you have a TV in your bedroom? \_\_\_Yes \_\_\_No

5. Do you have a stereo or radio in your bedroom? \_\_\_Yes \_\_\_No

6. Is there a desk with paperwork to be done in your bedroom? \_\_\_Yes \_\_\_No

7. Do you have a computer in your bedroom? \_\_\_Yes \_\_\_No

8. Do you have exercise equipment in your bedroom? \_\_\_Yes \_\_\_No

9. Do you ever eat/snack in your bedroom? \_\_\_Yes \_\_\_No

10. Do you read in bed before bedtime? \_\_\_Yes \_\_\_No

11. What is your bed room temperature at night? \_\_\_Cool/Cold \_\_\_Warm/Hot \_\_\_Just Right/Comfortable

**Section 7: Symptoms of Sleep Problems**

During the past month, have you or your spouse ever noticed one of the following:

1. Crawling or aching feelings in your legs (calves) \_\_\_Yes \_\_\_No

2. An inability to keep your legs still \_\_\_Yes \_\_\_No

3. Leg twitches or jerks during the night \_\_\_Yes \_\_\_No

4. Waking up with cramps in your legs \_\_\_Yes \_\_\_No

5. Snoring \_\_\_Yes \_\_\_No

6. Pauses in your breathing at night \_\_\_Yes \_\_\_No

7. Choking at night \_\_\_Yes \_\_\_No

8. Gasping for air during the night \_\_\_Yes \_\_\_No

9. Morning headaches, chest pain, or dry mouth \_\_\_Yes \_\_\_No

10. Nightmares \_\_\_Yes \_\_\_No

11. Dream-like images (hallucinations) when awakening in the morning \_\_\_Yes \_\_\_No

12. Awakening from sleep screaming and confused \_\_\_Yes \_\_\_No

13. Sleepwalking \_\_\_Yes \_\_\_No

14. Sudden “attacks” of sleep during the day \_\_\_Yes \_\_\_No

15. Sudden muscular weakness in situations of strong emotions \_\_\_Yes \_\_\_No

16. Sour taste in mouth (heartburn or reflux) \_\_\_Yes \_\_\_No

17. Grinding your teeth at night \_\_\_Yes \_\_\_No

18. Rotating shift or night shift work \_\_\_Yes \_\_\_No

19. Feeling “panicked” during the night (heart pounding, anxious) \_\_\_Yes \_\_\_No

20. Nose blocking up (allergies, infections) at night \_\_\_Yes \_\_\_No

**Section 8: Medical History**

1. Please describe any medical problems you currently have (other than your sleep problem): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Have you had any recent hospitalizations or surgery? \_\_\_Yes \_\_\_No

3. Have you had any significant, recent weight gain or loss? \_\_\_Yes \_\_\_No

4. Are you currently being treated for a mental health problem? \_\_\_Yes \_\_\_No

5. Have you ever been treated for a mental health problem? \_\_\_Yes \_\_\_No

6. Have you ever been treated for an alcohol/substance abuse problem? \_\_\_Yes \_\_\_No

7. Has alcohol or any drug ever caused a problem for you? \_\_\_Yes \_\_\_No

8. What are the current stressors in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_