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Sleep Assessment

Thank you for taking the time to complete this extensive form. Sleep disturbances and/or fatigue are most often the result of many factors. In order to best treat your condition we need to understand your symptoms and history. Please bring your completed assessment form to your appointment.

To schedule an appointment please call 505 844-HBES (4237).

Name:		**Employee ID#:**	**Date:**
☐**Male** ☐**Female**	**Age:**	**Health Plan** : ☐ United ☐ BCBSNM ☐ Other:	

Referred by: _____

Sleep and Health History

In general, would you describe your sleep as: ☐Refreshing ☐Not Refreshing

How would you rate your sleep?

Very Good	Good	Adequate	Poor	Very Poor
☐	☐	☐	☐	☐

How would you describe your sleep problem?

Sleep Problem (indicate all that apply)	**Duration of problem**	
Insomnia	Months	Years
Nightmares	Months	Years
Poor Sleep Quality	Months	Years
Sleep Breathing Problem	Months	Years
Sleep Movement Problem	Months	Years
Other:	Months	Years

On average, how long does it usually take you to fall asleep?

On average, how many hours do you usually spend in bed a night?

On average, how many hours of sleep do you usually get in a night?

Do you wake up during your sleep? ☐YES ☐NO

If yes, how many times per night on average?

If awakened, do you have trouble returning to sleep? ☐YES ☐NO

If awakened, how much time awake do you spend at night trying to get back to sleep?

Would you or others say you snore loudly? ☐YES ☐NO ☐ Don't Know

Have you or others moved from the bed because of your snoring? ☐YES ☐NO ☐ N/A

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Sleep and Health History Continued

Would you or others say that you have other trouble breathing while you sleep – do you stop breathing, choke, gasp, or struggle for breath? ☐YES ☐NO ☐ Don't Know

While lying still in bed, do you have uncomfortable sensations in your legs that prevent you from sleeping? ☐YES ☐NO

If yes, do these sensations go away when you move your legs? ☐YES ☐NO

Would you or others say that you twitch or jerk your legs while you sleep? ☐YES ☐NO

Have you or others ever moved from your bed because of your twitches/leg jerks?
☐YES ☐NO ☐ N/A

Would you ever have described yourself as a "good" sleeper? ☐YES ☐NO

When do you have the highest energy level?

When do you have the lowest energy level?

Please describe how fatigue or low energy affects your daily activities:

Indicate which, if any, symptoms you've been having at least weekly during the past month:

☐Wake up with dry mouth
☐Problems controlling your blood pressure
☐Morning headaches
☐Difficulty concentrating
☐Other
☐Difficulty with memory
☐Feeling anxious
☐Disturbing dreams or nightmares
☐ Feeling depressed/moody

Indicate which, if any, of the items listed below wake you up or keep you from sleeping:

☐Restless legs or leg jerks
☐Trouble breathing
☐Indigestion/ Reflux
☐Needing to use the bathroom
☐Needing to care for a child, elder, pet etc.
☐ Needing a drink of water
☐Racing thoughts/ Can't turn off your mind
☐Anxiety or fear/worry about something
☐ Other
☐ Pain (if yes, describe)

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Sleep and Health History Continued

Please list any medications, supplements or vitamins, prescribed or over the counter, you are currently using on a regular basis for any condition:

Medication	Dose	Taken For	How long have you been taking this medication?	Any side effects noted?

Do you have any allergies to medications? ☐YES ☐NO If yes, please list. _____

Please list any medications, supplements, vitamins, oxygen, CPAP, nasal strips, dental devices etc. that you use to improve your sleep:

When was your last complete physical exam?

Have you had an overnight sleep study or visited a sleep medicine doctor? ☐YES ☐NO

Have your tonsils and/ or adenoids been removed? ☐YES ☐NO

Have you had any sinus surgeries? ☐YES ☐NO

Do you have any problems with allergies ☐YES, seasonal ☐YES, all year round ☐NO

Have you had problems with sinuses? ☐YES, seasonal ☐YES, all year round ☐NO

Have you had any sinus infections in the past three years? ☐YES ☐NO

Do you know if or have you ever been told that you grind or clench your teeth? ☐YES ☐NO

Do you have asthma or other lung disease? ☐YES ☐NO

Do you have any gastrointestinal issues (reflux, constipation, diarrhea…)? ☐YES ☐NO

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Sleep and Health History Continued

For women – do you have any menstrual or menopausal issues, such as irregular periods, painful menstrual cramps, heavy bleeding, sleep disturbance associated with menstrual cycle, hot flashes or night sweats… Please describe

Do you have any chronic condition(s)/disease(s)? ☐YES ☐NO
If yes, please list:

Anything else you think important to share regarding your medical history?

Do you have a family history of any of the following? (Please indicate)

☐ Diabetes	☐ Heart disease	☐ High blood pressure
☐ Stroke	☐ Sleep apnea	☐ Restless leg syndrome
☐ Insomnia	☐ Depression	☐ Thyroid disease
☐ Anxiety	☐ Other:	

Life Balance

How many hours, if any, do you work over your normal work schedule each week?

Do you take at least a 30 minute break away from your work each day? ☐YES ☐NO

Do you take time to relax each day? ☐YES ☐NO

What, if any, activities or techniques do you use to relax or manage your stressors?
Please list:
How much time do you spend watching TV/ playing computer games / or other non work related computer activities? per day per week

Do you have regular opportunities to socialize with friends/ peers/ family? ☐YES ☐NO

Do you have any special interests or hobbies (exclude work related activities)? ☐YES ☐NO

If yes, are you satisfied with the amount of time you get to pursue these interests? ☐YES ☐NO

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Life Balance continued

On a scale of 0 to 10, how satisfied are you with your job?

Not Satisfied ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extremely Satisfied

On a scale of 0 to 10, how well do you feel that you balance your work and your life?

Not Balanced ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extremely Balanced

Do you tend to feel more anxiety/ stress or worry around bedtime? ☐YES ☐NO

Do you feel anxious or worried about going to bed? ☐YES ☐NO

Do you feel anxious or worried about the next day if you do not sleep well? ☐YES ☐NO

Over the past 2 weeks, how often have you been bothered by any of the following problems? (Please indicate)	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
Feeling down, depressed or hopeless	☐0	☐1	☐2	☐3

Sleep Hygiene

Do you set an alarm clock? ☐YES ☐NO
If yes,
I usually set an alarm clock. On workdays I set my alarm for_____. I wake up at _____ and I get out of bed at_____. On weekends ☐ I set my alarm for_____ **or** ☐ I do not set my alarm. I wake up at _____ and I get out of bed at_____.
If no,
I do not use an alarm clock. On workdays I wake up at _____ and I get out of bed at_____. On weekends I wake up at _____ and I get out of bed at_____.

Do you participate in regular exercise? ☐YES ☐NO
If yes, how many hours of exercise do you get in the average week?
What types of activity do you participate in?
How many hours before bed do you exercise?

Do you nap? (this includes things like napping on the couch the evening an unintentional napping even for just a few minutes) ☐YES ☐NO

If yes, how often and for how long?

Do you have a comfortable sleep environment? This means an environment that includes: a comfortable bed, comfortable bedroom temperature, a clean, quiet and darkened bedroom.
☐YES ☐NO

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Sleep Hygiene Continued

Do you have techniques or rituals to help you relax at bedtime? Such as taking a warm bath, listening to relaxing music, deep breathing, or imagery. ☐YES ☐NO

How soon after you awaken are your eyes exposed to sunlight? _____

How many hours before bed do you finish eating? _____

Do you use tobacco? ☐YES ☐NO
If yes, how many hours before bed do you use tobacco? If you wake during the night do you use tobacco? ☐YES ☐NO

Do you check the time if you awaken at night? ☐YES ☐NO

If you awaken at night do you stay in bed trying to return to sleep? ☐YES ☐NO

Do you drink coffee or other caffeine containing beverages? ☐YES ☐NO
If yes, on average how many beverages containing caffeine do you consume a day? _____ (Count an 8oz. serving as one beverage. For example: a can of soda is 12oz. = 1 ½ beverages.) How late in the day do you usually drink a caffeinated beverage? _____

Do you drink alcohol?
If yes, how much alcohol do you usually have, at what time of the day and how many days per week? _____

How do you decide when to go to bed? (check all that apply)
☐ Time ☐ Feel sleepy ☐ Feel bored ☐ Feel tired
☐ Spouse/significant other's bed time ☐ Think I should to get enough sleep

Other than sleep or sex, what activities do you use your bedroom for? (Please check all that apply)
☐ Watching TV ☐ Paying bills ☐ Discussing the problems of the day
☐ Studying or work activities ☐ Email/ computer work ☐ Exercise
☐ Other:

Please describe your bedtime routine (what do you do in the hour before you go to bed):

What do you believe is causing your sleep disturbance?
☐Not Sure
Please describe:

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Insomnia Severity Index

Please answer each of the questions below by indicating the response that best describes your sleep patterns in the past week. Please answer all questions.

Please rate the current (past week's) SEVERITY of your insomnia problem(s):	0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Difficulty falling asleep:	☐	☐	☐	☐	☐
Difficulty staying asleep:	☐	☐	☐	☐	☐
Problem waking up too early:	☐	☐	☐	☐	☐

How SATISFIED/DISSATISFIED are you with your current sleep pattern?	Very Satisfied ☐	A Little ☐	Some What ☐	Much ☐	Very Dissatisfied ☐
To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?	Not at all Interfering ☐	A Little ☐	Some What ☐	Much ☐	Very Much Interfering ☐
How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?	Not at all Noticeable ☐	A Little ☐	Some What ☐	Much ☐	Very Much Noticeable ☐
How WORRIED/DISTRESSED are you about your current sleep problem?	Not at all ☐	A Little ☐	Some What ☐	Much ☐	Very Much ☐

Total: _____

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Epworth Sleepiness Scale

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 circle the most appropriate number for each situation:

Situation:	**Chance of dozing:**			
	0 would never dose	1 slight chance of dozing	2 moderate chance of dozing	3 high chance of dozing
Sitting & Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theater or movie)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting & talking with someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total: _____