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Sleep Intake Packet

Section A — Main Sleep Concern

1. What is your main sleep complaint?

_____

2. How long has this been a problem?

_____

3. Were there any events (weight gain, stress, illness, etc.) associated with onset?

_____

4. Have you had a sleep study or home screen? When/Where?

_____

5. Have you used CPAP/BiPAP? If so, how long? Pressure setting? Mask?

_____

Section B — Epworth Sleepiness Scale (ESS)

Circle the most appropriate number for each situation: 0 = never, 3 = high chance of dozing.

1. Sitting and reading — 0 1 2 3

2. Watching television — 0 1 2 3

3. Sitting inactive in public — 0 1 2 3

4. Passenger in car for an hour — 0 1 2 3

5. Lying down to rest in afternoon — 0 1 2 3

6. Sitting and talking to someone — 0 1 2 3

7. Sitting quietly after lunch (no alcohol) — 0 1 2 3

8. In a car, stopped in traffic — 0 1 2 3

Total: _____

Section C — STOP-Bang Questionnaire

Do you snore loudly (louder than talking or heard through doors)? — ☐ Yes ☐ No

Do you often feel tired, fatigued, or sleepy during the daytime? — ☐ Yes ☐ No

Has anyone observed you stop breathing during sleep? — ☐ Yes ☐ No

Do you have or are you being treated for high blood pressure? — ☐ Yes ☐ No

BMI more than 35 kg/m²? — ☐ Yes ☐ No

Age over 50 years old? — ☐ Yes ☐ No

Neck circumference > 40 cm / 16 in? — ☐ Yes ☐ No

Male gender? — ☐ Yes ☐ No

Score: _____ (0–2 Low risk, 3–4 Intermediate, 5–8 High risk)

Section D — Restless Legs Syndrome (RLS) Questionnaire

Do you have an urge to move your legs, usually accompanied by uncomfortable sensations? — ☐ Yes ☐ No

Do these begin or worsen during periods of rest or inactivity? — ☐ Yes ☐ No

Are these partially or totally relieved by movement (walking, stretching)? — ☐ Yes ☐ No

Are these worse in the evening or night than during the day? — ☐ Yes ☐ No

Severity (0–10): _____ Nights per week: _____

Section E — Additional Sleep Symptoms (0–4 scale)

Circle one number per line if applies: 0= Never 1= Sometimes 2= Often 3 = Always

Sleepy or dozing when driving — 0 1 2 3

Sleepy at work — 0 1 2 3

Take intentional naps — 0 1 2 3

Feel unable to move (paralyzed) when falling asleep — 0 1 2 3

Suddenly awaken choking or gasping — 0 1 2 3

Grind teeth — 0 1 2 3

Hold breath or told you stop breathing — 0 1 2 3

Overall sleepiness (self-rating) — 0 1 2 3

Short periods of muscle weakness, esp. with laughter/excitement — 0 1 2 3

Need sleeping pill (Rx or OTC) to fall asleep — 0 1 2 3

Nightmares — 0 1 2 3

Uncomfortable/restless leg sensations relieved by moving — 0 1 2 3

Toss and turn / restless sleep — 0 1 2 3

Walk or talk in your sleep — 0 1 2 3

Snore — 0 1 2 3

Vivid dream-like episodes when falling asleep — 0 1 2 3

Awaken with heartburn or acid reflux — 0 1 2 3

Wake with dry mouth — 0 1 2 3

Morning headaches — 0 1 2 3

Move about or aggressive behaviors while asleep / on awakening — 0 1 2 3

Use alcohol to fall asleep — 0 1 2 3

Use sleeping pills or OTC aids nightly > 3 weeks — 0 1 2 3

Lie awake > 30 minutes unable to fall asleep or return to sleep — 0 1 2 3

Dread going to bed because you feel you will not fall asleep — 0 1 2 3

Overall sleep quality (self-rating) — 0 1 2 3

Section F — Sleep Habits

1. Bedtime weekdays/weekends: _____

2. How long to fall asleep? _____

3. Position: Back ___% Side ___% Stomach ___%

4a. How often awaken? _____ 4b. How long awake? _____ 4c. Reason? _____

5. Wake time weekdays/weekends: _____

6. Hours of sleep: _____

7. How do you feel in morning? ☐ Very sleepy ☐ Sleepy ☐ Wide awake

8. Function best: Morning ☐Best ☐Medium ☐Worst / Afternoon ☐Best ☐Medium ☐Worst / Evening ☐Best ☐Medium ☐Worst

Section G — Medical History

Please outline your medical history: Do you have or have ever been told you have:

□ Blood Pressure	□ Cholesterol	□ Migraine or Frequent Headaches
□ Sinus Problems	□ Stroke	□ Frequent Nighttime Urination
□ Diabetes	□ GI Disease	□ Dementia (Alzheimer's, etc.)
□ Arthritis	□ Cancer	□ Prior History of Sleep Apnea
□ Thyroid Problems	□ Parkinson's	□ Prior History of Restless Legs
□ Anemia	□ Depression/Anxiety	□ Obesity
□ Heart Disease	□ Liver isease	□ Abnormal behavior during sleep
□ Lung Disease	□ Seizures or Epilepsy	

1. Your weight? _____ Your height? _____
2. Do you smoke? _____If yes, how long? _____How much? ____/ day
3. Do you drink alcohol? _____ If yes, how long? _____How many drinks? ____/ day/wk/mo
4. Do you drink energy drinks, coffee, tea or soda? _____ How many drinks? ____/ day/wk/mo

Section H — Bed Partner Observations

TO BE COMPLETED BY BED PARTNER

Check any of the following behaviors that you have observed the patient doing while asleep:

□ Loud Snoring	□ Grinding teeth	□ Getting out of bed while asleep
□ Sitting up in bed	□ Talking in sleep	□ Rocking or banging head
□ Twiting of legs or feet	□ Sleep Walking	□ Kicking legs while asleep
□ Pauses in breathing	□ Becoming very rigid and/or shaking	

How long have you been aware of the sleep behaviors that you have checked above?

_____

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Describe the behaviors checked above in detail. Include the description of activity, time it occurs, frequency during the night and whether it happens every night.

_____

_____

_____

Any additional comments:

_____