

Sleep/Fatigue Questionnaire

Name _____ Age _____

Date _____ Referred by _____

Referring Dr.'s Phone # and Email: _____

1. Do you have trouble sleeping? Y N
- Do you feel rested when you wake up? Y N
- Are you a light sleeper, awoken easily? Y N
- Do you toss and turn in your sleep? Y N
- Rate your overall daily energy level: Low Less than Before Normal High

How many hours of sleep do you get on average per night _____ hours

How many hours of sleep would you like to get? _____ hours

Circle: It takes me on average about: 5 10 15 20+ minutes to fall asleep.

Choose: ___ I sleep through the night ___ I wake in middle of sleep on average _____ times a night.

Check all that apply to what wakes you:

- ___ Need to go to the bathroom ___ Pain ___ Sleep partner
- ___ Legs muscle spasm ___ Room noise ___ Other- _____

In which position do you sleep: Back Side Stomach

Do you take any medications to help you sleep? Y N

Please List: _____

Do you snore? Y N

Do you have a sleep partner? Y N

Does your sleep partner snore? Y N

Do you sleep in a different room as your partner? Y N Sometimes

Do you have any trouble breathing during sleep? Y N

Have you ever woken up gasping or choking? Y N

Are your legs comfortable when you sleep? Y N

Do you consider yourself under a lot of stress? Y N

Do you worry? Y N

Do you ever get depressed? Y N

How often? _____

2. Do you typically breath through your mouth instead of your nose? Y N

Do you have any sinus problems? Y N

List _____

Please do not write in this space.

3. Have you ever had a stomach problem? Y N
- Ulcers GERD Acid Reflux Y N
- Rate the nutrition of your diet: Excellent Good Could be better Poor
- Do you use vitamin supplements? Y N
- Women: do you take an iron supplement? Y N
- Do you exercise? Y N
- Do you currently use (circle): Caffeine Alcohol Tobacco products Nicotine
- Amount of Caffeine per day: _____
- Amount of Alcohol: _____

Please do not write in this space.

4. Check all that apply:

- ☐ I go to bed most nights at the same time. ☐ My sleep schedule is inconsistent.
- ☐ I wake up most days at the same time
- ☐ I do not need an alarm to wake up most days ☐ I need an alarm to wake me up

Check all that apply about the room you sleep in:

- ☐ Room is quiet ☐ Room is noisy
- ☐ My sleep partner snores ☐ My sleep partner tosses and turns
- ☐ Room is dark ☐ I watch TV in bed
- ☐ Room temperature is comfortable ☐ Room is too warm ☐ Room is too cold

Check all that apply to you when you sleep:

- ☐ Feet are comfortable temperature ☐ My feet are cold ☐ I wear socks
- ☐ Body is comfortable temperature ☐ Body is too warm ☐ I sweat
- ☐ Body is cold ☐ I wear extra clothes

Check all that apply about your evening meal:

- ☐ I eat a small dinner ☐ Dinner is my largest meal of the day.
- ☐ I eat early ☐ I eat dinner late 3+ times a week
- ☐ I often skip dinner ☐ I have snack in the evening before bed

Circle which of the following you have done in the past 2 weeks in the HOUR prior to sleep:

Read a book, magazine Eaten food Watched TV On computer, Tablet, phone
Meditation Stretching other_____

5. Date of last medical physical: _____

Have you had a Sleep Test by a Physician? Y N Date of sleep test: _____

Were you diagnosed with Obstructive Sleep Apnea? Y N Was CPAP recommended? Y N

CPAP Use (circle all that apply): Every Night Most nights. Some Nights Not used

When CPAP is used, how long is it worn? All night Half the night

6. Do you get headaches? Y N
How often? _____
Do you clench your teeth? Y N
Do you grind your teeth? Y N
Any discomfort when you move your jaw? Y N
Any discomfort upon chewing hard foods like carrots? Y N

Please do not write in
this space.

7. What would you like to improve with treatment here?

8. Is there anything else that I should know about?

10. I have completed all 3 pages to the best of my knowledge and I personally have filled in each blank.

signature

date