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PSY 25438

Sleep Intake Form

Name: ______________________________ Sex: ________ Age: _______

My main sleep complaint(s) Is:

Sleep Pattern

	Weekdays	Weekends
Typical bedtime:	____________	____________
Typical amount of time it takes to fall asleep:	____________	____________
Typical number of awakenings per night:	____________	____________
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	____________	____________
Typical amount of time to fall back asleep after an awakening:	____________	____________
Typical wake up time:	____________	____________
Desired wake up time:	____________	____________
How do you usually awaken, i.e., alarm clock?:	____________	____________
Typical time you get out of bed:	____________	____________
Total amount of sleep per night:	____________	____________
Number of naps per day:	____________	____________

Please check all of the following statements that are true about your sleep:

Sleep Habits

- ☐ I usually watch TV or read in bed prior to sleep
- ☐ I drink alcohol prior to bedtime
- ☐ I smoke prior to bedtime or when I awaken during the night
- ☐ I eat a snack at bedtime
- ☐ I eat if I wake up during the night
- ☐ I typically wake up from sleep to go to the bathroom
- ☐ I have trouble falling asleep
- ☐ I often wake up during the night
- ☐ I am unable to return to sleep easily if I wake up during the night
- ☐ I have thoughts that start racing through my mind when I try to fall asleep
- ☐ I wake up early in the morning, and I am still tired but unable to return to sleep
- ☐ I have nightmares

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- [ ] I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- [ ] I sweat a great deal during sleep
- [ ] I cannot sleep on my back

Breathing

- [ ] I have been told that I stop breathing while I sleep
- [ ] I wake up at night choking, smothering or gasping for air
- [ ] I have been told that I snore
- [ ] I have been told that I snore only when sleeping on my back
- [ ] I have been awakened by my own snoring

Restlessness

- [ ] I have uncomfortable feelings in my legs and/or arms when I lie down at night
- [ ] I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- [ ] I am a restless sleeper
- [ ] I have been told that I kick or jerk my legs and/or arms during sleep
- [ ] I have a hard time falling asleep because of my leg movements
- [ ] I talk in my sleep
- [ ] I walk in my sleep
- [ ] I grind my teeth in my sleep

Daytime Sleepiness

- [ ] I take daytime naps
- [ ] I have a tendency to fall asleep during the day
- [ ] I have had "blackouts" or periods when I am unable to remember what just happened
- [ ] I have fallen asleep while driving
- [ ] I have had auto accidents as a result of falling asleep while driving
- [ ] I fall asleep while watching TV
- [ ] I fall asleep during conversations
- [ ] I fall asleep in sedentary situations
- [ ] I perform poorly in school because of sleepiness
- [ ] I have had injuries as the result of sleepiness
- [ ] I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- [ ] I have had an inability to move while falling asleep or when waking up
- [ ] I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- [ ] I drink caffeinated beverages during the day: _____cups/bottles/cans per day

Habits

Do you smoke? ☐ Yes ☐ No

If Yes:	What?	Amount per Day	For How Many Years
	☐ Cigarettes	___________ pack(s)	___________ years
	☐ Cigars	___________ cigars	___________ years
	☐ Tobacco	___________ pipes	___________ years

Do you drink alcohol? ☐ Yes ☐ No

If Yes:	What?	Frequency			Amount per Week
	☐ Beer	☐ Daily	☐ Weekends	☐ Rare	________ cans/week
	☐ Wine	☐ Daily	☐ Weekends	☐ Rare	______ glasses/wk
	☐ Liquor	☐ Daily	☐ Weekends	☐ Rare	_______ shots/week

Social History

☐ Sleep alone
☐ Share a bed with someone
☐ Share a bedroom, but have separate beds

Medical History

Vital Statistics

What is your: Height? ____ feet _____inches
Weight? _______ pounds
Recent ☐ Weight loss ☐ Weight gain

Current Medications

Medication Name	How much?	How often?	Last taken?

Allergies:

____

Past Sleep Evaluation and Treatment

☐ I have had a previous sleep disorder evaluation
☐ I have had a previous overnight sleep study
☐ I have had a daytime nap study
☐ I have been prescribed a CPAP or bilevel PAP machine for home use
☐ I have had surgical treatment for a sleep disorder
☐ I have previously been prescribed medication for a sleep disorder
☐ I have previously been treated for a sleep disorder

Past Medical History

☐ Hypertension (high blood pressure)
☐ Heart Disease
☐ Diabetes
☐ Hepatitis/jaundice
☐ Hearing impairment
☐ Depression or severe anxiety

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- ☐ Stomach or colon problems
- ☐ Lung problems/COPD/asthma
- ☐ Reflux
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Cancer

Female

- ☐ Fibromyalgia
- ☐ Premenstrual syndrome

Male

- ☐ Prostate problems
- ☐ Erectile dysfunction/impotence

- ☐ Alcoholism
- ☐ Chemical dependency or abuse
- ☐ Blackouts
- ☐ Seizures
- ☐ Back or joint problems (arthritis)

List other past medical problems and dates:

Medical Problem	Date

List Surgeries and the year

Surgeries	Year

Family History

Has an immediate blood relative had any of the following?

	Relation
☐ Anxiety/Depression	______________
☐ Sleep Apnea	______________
☐ Narcolepsy	______________
☐ Insomnia	______________
☐ Other: ______________	______________