Client ID: _____ Date: _____

Evaluator: _____ Appointment: _____

Sleep habits (focus on a recent typical week):

Beginning of Sleep Period:

If different: Weekend

Time to bed (obtain range and weekday/weekend times): _____ _____

Time of lights out: _____ _____

Average time to fall asleep: _____ _____

What you do when you cannot sleep? _____

_____

Pre bedtime activities: _____

_____

Pre sleep arousal: Rumination worry physical tension fears

_____

_____

What happens when you cannot get to sleep (thoughts/behaviors)? _____

_____

Middle of the night:

If different: Weekend

Number of awakenings after sleep onset: _____ _____

Total time awake after sleep onset: _____ _____

(Average/worst/timing of prolonged wakefulness): _____

_____

What happens when awake in the middle of the night (thoughts/behaviors): _____

_____

End of the night:

Final wake time: _____ _____

Time out of bed: _____ _____

Early morning awakenings (within 1-3 hours of intended wake time):

How much earlier than intended? _____ _____

Number of days a week: _____ _____

Difficulties waking up at intended time: _____ _____

Estimated average total sleep time: _____ _____

Naps

Ability to nap if given an opportunity: Yes / No

If napping: Frequency _____ duration _____ timing _____

Daytime effects:

Energy/fatigue: _____ Concentration/functioning: _____ Mood: _____

Other _____

History:

When did the problem start? _____

_____

Identifiable precipitating factor: _____

_____

Family history of insomnia and other sleep disorders: _____

_____

Circadian tendencies (circadian rhythm questionnaire and interview):

___Morning type _____ Neither type _____ Evening type Evidence: _____

_____

Sleep medication(s)/aids:

Name	Dose	Manner used (@ BT, Middle of night; PRN)	How long?	Helpful?

Obstructive sleep apnea (OSA) symptoms: STOP questionnaire score _____

___ Snoring ___Gasping/snorting ___ Witnessed apnea ___ Daytime sleepiness

PLM/RLS symptoms: ___ Leg jerks, twitches (witnessed) ___aching, tingling creeping

___ Moving for relief RLS questionnaire score (if administered): ___

Parasomnia symptoms:

Nightmares: _____

- Have you been having repeated nightmares that have imagery or a storyline you remember?
- Do they wake you up?
- Approximately how many nightmares have you experienced in the past week?_____
    - Past month?_____
- How many nights in the past week have you experienced a nightmare? _____
    - Experienced more than one nightmare in a night?_____
- In general, how disturbing are the nightmares?_____
- How many different nightmares do you typically experience?_____
- Did these nightmare start or get worse after a traumatic experience?
- How similar are they to the actual event you experienced?_____
- What time of night do you generally wake from a nightmare?____
- What types of symptoms do you experience after waking? (heart racing, sweating ,etc) ____
- How long does it take for you to fall back asleep?_____
    - How much sleep do you think you lose?

Substances (inquire about amount and time of day)

Caffeine _____ Nicotine _____

Alcohol _____ Recreational drugs _____

Unhealthy sleep practices:

Nocturnal eating _____ Timing of exercise _____

Unusual aspects of sleep environment (bed partner, childcare, pets, comfort, sound, lights, safety, temperature): _____

_____

Medical comorbidities: _____

_____

Psychiatric comorbidities: _____'

_____

Suicide Screen: Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

□ Not at all □ Several Days □ More than Half the Days □ Nearly Every Day

If suicidal thoughts endorsed, proceed with sleep clinic suicide screen*

Other medications (non-VA):

Name	Reason prescribed	Dosage	How long?

Goal:

_____