

Sleep Health Institute
Dr. Ronald Cridland Inc.
Sleep Questionnaire

Name: _____ Date: d/m/yr _____

	Work Days	Non-workdays
What time do you go to bed?	_____	_____
How long does it take for you to fall asleep?	_____	_____
Estimate the number of times you wake up during the night?	_____	_____
Average time it takes you to return to sleep?	_____	_____
What time do you finally wake up in the morning?	_____	_____
What time do you actually get up?	_____	_____
Estimate average number of hours of actual sleep, including light sleep?	_____	_____
If you usually use an alarm, what time is it set for?	_____	_____
Do you feel rested when you get up?	_____	_____
How many hours of sleep do you normally need to feel rested? _____		

In the following situations, please use this scale to rate the likelihood of you actually DOZING or FALLING ASLEEP (not just feeling tired or sleepy). This refers to falling asleep during the day or evening, not at bedtime when you would normally fall asleep. This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate how they would have affected you:

	Never	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g.: theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

How long have you had trouble with your sleep? _____

What triggered your difficulty sleeping? _____

Do you perform shift-work? Yes No Recent travel across more than 1 time zone? Yes No

How much caffeine do you use per day? _____ Do you have caffeine after 4 pm? Yes No

How much nicotine do you use per day? _____ Do you smoke during the night? Yes No

How much alcohol do you use per week? _____ Do you drink within 2 hours of bed? Yes No

Do you use any other recreational drugs? _____

How many days a week do you exercise? _____ Do you exercise within 2 hours of bed? Yes No

Please check all of the following statements that apply to you **on a regular basis**:

- I have "restless legs" (trouble getting my legs comfortable or keeping them still).
 - I have to stretch my legs or get up and walk around because of the uncomfortable feeling in my legs.
 - I get "creepy-crawly" sensations in my legs when sitting for long periods of time.
 - These sensations in my legs frequently make it hard for me to fall asleep.
 - I have iron deficiency or anemia.
 - Chronic pain is a more significant cause of my disturbed sleep than restless legs.

 - I have a habit of thinking, worrying, planning or problem solving in bed.
 - When in bed, I watch the clock.
 - When lying awake, I feel anxious or frustrated about my inability to sleep.
 - I feel nervous or tense in bed.
 - I look forward to bedtime with anxiety or dread.
 - I am a light sleeper and hear every little noise.

 - I have been told that I snore loudly in my sleep.
 - I have been told that I stop breathing, choke or gasp in my sleep.
 - I am aware of waking myself snorting, gasping or choking
- Height: _____ Weight: _____ Collar size: _____
- I have been told that I frequently twitch, kick, or jerk in my sleep.
 - I have sciatica, numbness or tingling in my legs.

 - I have been told that I talk, scream, walk or eat in my sleep.
 - This significantly disrupts the sleep of my bed-partner.
 - I am concerned about harming myself or someone else in my sleep.

 - I sometimes wake up hallucinating that something is in the room that really is not there.
 - I sometimes wake up paralyzed, unable to move for a few seconds or minutes.
 - I sometimes get so sleepy during the day that I fall asleep when I don't want to.
 - I sometimes do something (like driving somewhere) and don't remember doing it.
 - In response to a strong emotional event, such as laughing, surprise or anger, I can suddenly become so weak that my knees buckle, my head droops, my jaw drops, I have trouble speaking, or I fall down.
 - Someone in my family has similar problems to those listed in the previous 5 statements.

 - I have been told that I grind my teeth in my sleep.
 - I wake up with a headache or a sore jaw.