## *Sleep Disorder Assessment Form* Complete the form and email to drdebby@deborahbernardo.com *

| Patient's Name (Last, First, Middle Name) | Birthdate | Age | Sex | Civil Status | Do you have a regular bed partner?<br>____NO ____YES ☐ Human<br>☐ Pet |
|---|---|---|---|---|---|
| Contact No. E-mail address: | | | | | |

| | | Tick the boxes that best describe your experiences over the past 3 months | | | |
|---|---|---|---|---|---|
| | | NEVER | OCCASIONALLY | MOST NIGHTS / DAYS | ALWAYS |
| 1 | Do you have trouble falling asleep? | | | | |
| 2 | Do you wake up often during the night? | | | | |
| 3 | Do you wake up too early? | | | | |
| 4 | Do you wake up un-refreshed? | | | | |
| 5 | Do you take anything to help you asleep? | | | | |
| 6 | Do you use alcohol to help you asleep? | | | | |
| 7 | Do you have any medical condition that disrupts your sleep? (e.g. pain, recent surgery, etc. ) | | | | |
| | | | | | |
| 8 | Are you a shift worker or is your sleep schedule irregular? | | | | |
| | | | | | |
| 9 | Are your legs restless and/or uncomfortable before bed? | | | | |
| 10 | Have you been told that you are restless or that you kick your legs in your sleep? | | | | |
| 11 | Do you have any unusual behaviors or movement during sleep? | | | | |
| | | | | | |
| 12 | Do you snore? | | | | |
| 13 | Has anyone said that you stop breathing, gasp, snort or choke in your sleep? | | | | |
| 14 | Do you have difficulty staying awake during the day? | | | | |
| | | | | | |
| 15 | Have you lost interest in hobbies or activities? | | | | |
| 16 | Do you feel sad, irritable or hopeless? | | | | |
| 17 | Do you feel nervous or worried? | | | | |
| | | | | | |
| 18 | Does your sleep problem affect your work or social life? | | | | |
| 19 | How much does your sleep problem bother you? | | | | |

*** If answers to QUESTIONS 1 – 7 are significant, it is highly recommended that you include a 2-week Sleep Diary from: https://www.deborahbernardo.com/fact-sheets**