



Insomnia Consult Questionnaire

Patient Name: _____ (Last / First)

Date: _____

Referring Doctor: _____

Primary Doctor: _____

Other Treating Doctors: _____

1. The patient's Insomnia has been present for _____ (yrs / months)
2. The patient's Insomnia has **improved / remained the same / become worse** in the past three months.
3. The patient's insomnia is primarily one of difficulty **falling asleep / staying asleep / both**.
4. The patient's Insomnia is **constant / varies** night to night.
5. The insomnia **does / does not** occur in cycles.
6. The Insomnia is present ___/ 7 nights per week if no sleeping pill is used?
7. If no sleeping pill is taken the typical time to fall asleep after going to bed is _____ hours.
8. If a sleeping pill is taken the typical time to fall asleep after going to bed is _____ hours.
9. The typical time to go to bed is: _____.
10. The typical time to get out of bed to start their day is: _____.
11. The estimated duration of time in bed is: _____.
12. The estimated duration of sleep is: _____.
13. The total amount of time awake during the middle of the night (after 1ST awakening) is: _____.

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3907 Waring Road, Suite 2
Oceanside, California 92056
P 760.631.3000
F 760-631-3016

320 Santa Fe Drive, Suite 108
Encinitas, California 92024
P 760.942.1390
F 760-942-4288

332 Santa Fe Drive, Suite 150
Encinitas, California 92024
P 760-631-3001
F 760-631-3016

Patient Name:



14. The patient's preferred time to fall asleep would be:_____.
15. The patient's preferred time to awaken would be:_____.
16. The patient would like to get _____ hours of sleep each night.
17. The patient remains awake in bed _____ hours before getting up.
18. When lying in bed unable to fall asleep the patient will:
do relaxation exercises / count sheep / lay still / get out of bed to help themselves fall back asleep.
19. The patient **does / does not** get upset when unable to fall asleep.
20. As bedtime approaches the patient **does / does not** feel more alert.
21. The patient feels most alert at: _____.
22. The patient **does / does not** feel refreshed on awakening.
23. The patient **does / does not** have teeth grinding or jaw clenching during sleep.
24. The patient **never / rarely / occasionally / frequently** has excessive sweating while asleep.
25. The patient **has / does not have** palpitations or tachycardia while asleep.
26. There **are / are not** specific precipitating factors which worsen the patient's insomnia.

Please list: _____

27. The patient **does / does not** use a sleeping pill to help them fall asleep.
These are used _____ nights per week.
28. The following medications have been used to treat your Insomnia: _____

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29. The other methods used to treat your insomnia are **warm bath / snack / reading / watch TV / listen to the radio / exercise / relaxation exercises / other** (please list below)

30. When the patient lays awake in bed trying to fall asleep they are thinking about **nothing in particular / family conflicts / work / financial problems / concern over not falling asleep / feeling tired the next day.**

31. The patient sleeps **alone / with spouse / with bed partner / with other family member.**

32. The patient sleeps in the **bedroom / living room / other room.**

33. The **bed / sofa / recliner** that you sleep in **is / is not** comfortable.

34. The patient **is / is not** bothered by noises when trying to fall asleep.

35. The patient uses **white noise machine / ear plugs / nothing** to decrease bothersome noise when trying to fall asleep.

36. The patient **has / does not have** to awaken for trips to the bathroom.

37. The patient **does / does not** get regular exercise. Please list the type & duration of the exercise:

38. The patient **does / does not** nap.

39. The napping occurs _____ days per week.

40. The typical duration of naps is _____ hours per day.

41. The patient **does / does not** have frequent leg movements at night.

42. There **are / are not** uncomfortable sensations at night.

43. These sensations are best described as **need to move the legs / creepy crawly sensation / restlessness / aching / tingling / pins & needles / pain.**

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44. This sensation **does / does not** interfere with falling asleep or staying asleep.
45. The patient snoring is **not noticeable / soft / loud / disruptive**.
46. The patient **does / does not** gasp for breath at night.
47. Pauses in the patient's breathing **are / are not** noted.
48. The patient's snoring **does / does not** disturb their sleep.
49. The patient **does / does not** drink caffeinated beverages.
50. The patient consumes ____ (12 ounce) caffeinated beverages per day.
51. The patient consumes ____ caffeinated beverages after noon each day.
52. The patient **does / does not** use other stimulants to remain alert. Please list below:
- _____
53. The patient **does / does not** smoke cigarettes.
54. The patient **does / does not** have a history of depression.
55. The patient's depression began **before / after** the insomnia developed.
56. The patient feels their insomnia is **mild / moderate / severe / disabling**.
57. There **is / is not** a family history of Insomnia. This was: _____
58. A poor night's sleep causes **daytime fatigue / sleepiness / poor concentration / poor memory / ability to work / depressed mood / irritable / anxious**.
59. Daytime sleepiness is **not present / mild / moderate / severe / disabling**.
60. Daytime fatigue is **not present / mild / moderate / severe / disabling**.
61. If the patient has a poor night of sleep they **are / are not** more likely to have a headache.

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EPWORTH SLEEPINESS SCALE

Answer with a number please do not use yes or no.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a movie theater or a meeting)	_____
At a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Score is _____

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Past Medical History

Medications

Medication Allergies

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332 Santa Fe Drive ♦ Suite 150 ♦ Encinitas, Ca. 92024 (760) 631-3001

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