THIBODAUX REGIONAL
SLEEP DISORDERS CENTER
604 N ACADIA ROAD, Suite 210
THIBODAUX, LA 70301

# INSOMNIA QUESTIONNAIRE

Name:_____ Date:

Address:

Phone (home):_____ Work:_____ Marital Status:

Date of Birth:_____ Height:_____ Weight:

In case of emergency contact:
**********
Social Security#:_____ Phone # of Insurance Co.:
Insurance Company_____ Policy No.:
Is policy private or group?_____ Subscriber:
If group, name of employer:
**********
Was this a self referral or physician referral?
If physician referral, physician name:
Physician's address:
**********
Current Occupation:_____ # of years in current work:
Birthplace:_____ Marital Status:_____ # of years
# of times married:_____ # of children, sex and ages
Any alcoholism or drug abuse in family members or self?
Educational level: # of years in high school_____ College_____ Other
Military experience, years and branch:
Any combat?_____ Any major criminal convictions?

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# INSOMNIA QUESTIONNAIRE

1. Please describe in your own words as briefly as possible you main problem:

_____
_____
_____
_____
_____
_____
_____

2. When was the first time this problem began? _____years ago

3. List all medications, tablets or other pills that you take to help you sleep. Indicate at what time you take each.

| **Medication** | **Dose** | **Time** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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**INSOMNIA QUESTIONNAIRE**

4. List anything else that you do to help you sleep, such as:
   Snack.....Yes/No
   Bath..... Yes/No
   Reading.....Yes/No
   Exercise..... Yes/No
   Relaxation Exeercise..Yes/No
   Other:

   How Often?

5. Do you do any of the following in bed at night?
   Read.....Yes/No
   Watch TV.....Yes/No
   Listen to the radio....Yes/No
   Other:

6. What type of bed do you sleep in? Single / Double / Queen / King
   Is your bed comfortable? .....Yes/No
   If not please explain why.:

7. Do you sleep alone? .....Yes/No
   If not, who do you sleep with?_____

8. Do you sleep on your: Left side / right side / back

9. What time do you usually turn out the bedroom light? _____pm/am.

10. Are you bothered by environmental noises at night? .....Yes/No
    If so please explain:

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**INSOMNIA QUESTIONNAIRE**

11. Do you use any of the following devices?
    White noise machines.....Yes/No
    Ear Plugs.....Yes/No
    Other:

12. On average how long does it take you to fall asleep?

13. What is the longest time it has taken you to fall asleep?

14. When you are in bed awake what do you think about?
    Trying to fall asleep.....Yes/No
    Family matters.....Yes/No
    Work.....Yes/No
    Other:

15. Do you get annoyed/angry when you cannot sleep?_____

16. Do you do anything in bed to help you get to sleep, such as:
    Relaxation exercises .....Yes/No
    Counting.....Yes/No
    Lying still.....Yes/No
    Other:

17. When you cannot get off to sleep, do you get out of bed?
    If so, how long after you have got into bed?
    If you get out of bed what do you do?

18. How long are you up for?

19. When you return to bed how long does it take you to fall asleep again?

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## INSOMNIA QUESTIONNAIRE

20. If you do not get out of bed, how long does it take for you to fall asleep?

21. Once you have fallen asleep, how long do you sleep for?
22. Do you awaken during the night?
    If so, on average how long are you awake for?

23. How often do you awaken during the night?

24. What time do you finally awaken?

25. What time do you get out of bed in the morning?

26. How do you feel on awakening in the morning?

27. If you slept poorly how does it affect you the next day?

28. Do you feel sleepy during the day?

29. Do you nap during the day?
    If so, how often and for how long?

30. What time of day do you nap?

31. If you do not nap, what time of day do you feel most tired?

32. What time of day do you feel most alert?
33. As your sleep period approaches, do you become more alert?
34. Do you worry during the daytime about the next nights sleep?
35. Does a poor night sleep make you:
    Depressed.....Y/N
    Anxiety.....Y/N
    Irritable.....Y/N

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## INSOMNIA QUESTIONNAIRE

Tired.....Y/N

36. Does a poor nights sleep affect your:
    Concentration.....Y/N
    Memory.....Y/N
    Ability to work.....Y/N

37. Do you toss and turn in bed?

38. Are you restless in bed?

39. Before you fall asleep at night do your legs feel achy?

40. Do you have to move them about in bed?

41. Do you have to get out of bed and walk around to ease you aching legs?
42. Do you get cramping of you calves?

43. When you are asleep do your legs jerk?

44. Do you have nightmares?
    If so, when did they begin?
    How often do they occur?

45. Please explain what your nightmares are about:

46. Do you get night terrors?
    If so, how often?

47. Do you sleep walk?

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**INSOMNIA QUESTIONNAIRE**

48. Do you snore?
    If so, how loudly?

49. Do you have breathing difficulties at night?
    If so, please explain:

50. Do your have heart palpitations at night?
    If so, please explain:

51. Do you drink caffeinated drinks?
    If so, what type_____How much?_____ How often?

52. Do you Smoke?
    If so, what type_____How much?_____How often?
53. Do you have regular meal time?
    If not, explain:

54. Do you eat a balance diet?
    If not, please explain:

55. Do you ever get depressed?
    If so, is it deep depression?

56. Please state when you were last able to sleep consistently without any problems:

57. What time did you then go to bed?

58. How long did it take you to fall asleep?

59. Did you awaken during the night?

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**INSOMNIA QUESTIONNAIRE**

If so, how often, and for how long:

60. What time did you awaken in the morning?

61. What time would you like to fall asleep at now?

62. How long would you like to sleep for?

63. What time would you like to awaken in the morning?

64. How long do you think normal people of your age sleep for?

65. Do you consider your sleep problem to be: mild / moderate / severe

66. Please add any other comments about your sleep problem that you think are relevant:

_____
_____
_____
_____

67. Please list all people whom you have consulted about your sleep problem. Starting with the first, list the date, name, degree, specialty, investigations, treatment, and outcome of all treatments (give details of medications on the next page).

| Date | Name | Degree | Specialty | Invest. | Treatment |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

68. Please list all medical illness that you have been treated for in the past, or are now under treatment for. Give the date, name of illness, treatment, and outcome.

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**INSOMNIA QUESTIONNAIRE**

69. Please list any operations that you have had:

70. List all medications you have been prescribed to help your sleep problem. Give the name, dosage, time they were taken, how long they were taken for, any beneficial effects, and why they were stopped. Start with the first one taken.

| Medication | Dose Time | Length | Effects | Stopped |
|---|---|---|---|---|

71. Family History (List any problems that run in the family, such as diabetes, hypertension, heart disease, psychiatric disorders, etc.)

Father:
Mother:
Brothers:
Sisters:
Grand Parents:

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**INSOMNIA QUESTIONNAIRE**

Aunts:
Uncles:

***Sleep Impairment Index***
***Page 1 of 3***

Please rate the current severity of you insomnia problem(s):

| | None | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|---|
| Difficulty falling asleep | 1 | 2 | 3 | 4 | 5 |
| Difficulty staying asleep | 1 | 2 | 3 | 4 | 5 |
| Problem waking up too early | 1 | 2 | 3 | 4 | 5 |

**How satisfied / dissatisfied are you with your current sleep pattern?**

| Very Satisfied | | Moderately Satisfied | | Very Dissatisfied |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

**To what extent do you consider your sleep problem to *interfere* with daily functioning (e.g., daytime fatigue, ability to function, at work/daily chores, concentration, memory, mood, etc)?**

| Not at all | A little | Somewhat | Much | Very Much |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

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## INSOMNIA QUESTIONNAIRE

**How *noticeable* to others do you think your sleeping pattern is in terms of impairing the quality of your life?**

| Not at all | A little | Somewhat | Much | Very Much |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

## *Sleep Impairment Index*
## *Page 2 of 3*

**How *concerned* are you about your current sleep problem?**

| Not at all | A little | Somewhat | Much | Very Much |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

**To what extent do you believe the following factors are contributing to your sleep pattern?**

| | None | | Some | | Much |
|---|---|---|---|---|---|
| Cognitive disturbances (racing thoughts at night) | 1 | 2 | 3 | 4 | 5 |
| Somatic disturbances (muscular tension / pain) | 1 | 2 | 3 | 4 | 5 |
| Bad sleeping habits | 1 | 2 | 3 | 4 | 5 |
| Natural aging processes | 1 | 2 | 3 | 4 | 5 |

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# INSOMNIA QUESTIONNAIRE

## *Sleep Impairment Index*


**After a poor night's sleep, which of the following problems do you experience on the next day?**

***CIRCLE ALL THOSE THAT APPLY***

*Daytime fatigue* tired exhausted washed out sleepy

*Difficulty functioning* performance impairment at work / daily chores

difficulty concentrating memory problems

*Mood problems* irritable tense / nervous depressed groggy

anxious grouchy hostile angry confused

*Physical symptoms* muscle aches / pain light-headed headache nausea heartburn muscle tension

*None*

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# INSOMNIA QUESTIONNAIRE

## *Treatment Acceptability*



Two treatment methods commonly used for insomnia problems are described below. Please read the description of each method and answer each question as it would apply to your insomnia problem. For each question, place a mark ( / ) somewhere along the continuous line wherever your *personal* rating falls. Please consider the line to represent your personal range. Try to use the whole scale, rather than putting your marks at one end or the other.

***EXAMPLE***

**I usually have trouble falling asleep.**

*Not at all Acceptable* _____/_____ *Very Much*

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# INSOMNIA QUESTIONNAIRE

***Treatment Acceptability***
***Page 2 of 5***

**TREATMENT ONE: BEHAVIORAL**

This is a *non-drug treatment* method aimed at teaching patients self-management skills to overcome insomnia. The behavioral component provides specific guidelines for changing poor sleep habits and for regulating sleep schedules. Patients are also guided to examine and modify their beliefs and attitudes about sleep that may perpetuate their insomnia. Education about sleep hygiene (e.g. diet, exercise, and substance use) is also provided.

*PLEASE complete all your ratings for this treatment before proceeding to read the description of the second treatment method.*

**How acceptable would you consider this treatment for your insomnia?**

*Not at all* _____ *Very Acceptable* *Acceptable*

**How acceptable would you consider this treatment for other people with insomnia?**

*Not at all* _____ *Very*

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**INSOMNIA QUESTIONNAIRE**

*Acceptable* *Acceptable*

**How willing would you be to adhere to this treatment regimen if recommended for your insomnia?**

*Not at all* _____ *Very*
*Willing* *Willing*

***Treatment Acceptability***
***Page 3 of 5***

**How suitable do you think this treatment would be for treating difficulty falling asleep at bedtime?**

*Not at all* _____ *Very*
*Suitable* *Suitable*

**How suitable do you think this treatment would be for treating difficulty staying asleep during the night?**

*Not at all* _____ *Very*
*Suitable* *Suitable*

**How effective do you believe this treatment would be in the short term?**

*Not at all* _____ *Very*
*Effective* *Effective*

**How effective do you believe this treatment would be for producing a permanent cure?**

*Not at all* _____ *Very*
*Effective* *Effective*

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# INSOMNIA QUESTIONNAIRE

**In addition to improving sleep, how effective would this treatment be for improving other aspects of your daytime functioning (e.g., alertness, performance, mood)?**

*Not at all* _____ *Very Effective* *Effective*

**To what extent would this treatment produce side effects?**

*Very strong* _____ *No Side Effects* *Side Effects*

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**INSOMNIA QUESTIONNAIRE**
***Treatment Acceptability***


**TREATMENT TWO: PHARMACOLOGICAL TREATMENT**

This *drug treatment* consists of taking a prescribed sleeping pill at bedtime. The prescribed hypnotic medication is specifically designed to produce a state of relaxation by reducing physiological (muscular) and cognitive (mental) arousal at bedtime. This medication also increases the threshold for awakening at night and makes patients less sensitive to factors that usually wake them up at night. The specific type of medication and dosage would be based on the nature and severity of the insomnia problem.

**How acceptable would you consider this treatment for your insomnia?**

*Not at all* _____ *Very*
*Acceptable* *Acceptable*

**How acceptable would you consider this treatment for other people with insomnia?**

*Not at all* _____ *Very*
*Acceptable* *Acceptable*

**How willing would you be to adhere to this treatment regimen if recommended for your insomnia?**

*Not at all* _____ *Very*
*Willing* *Willing*

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**INSOMNIA QUESTIONNAIRE**

***Treatment Acceptability***
***Page 5 of 5***

**How suitable do you think this treatment would be for treating difficulty falling asleep at bedtime?**

*Not at all Suitable* _____ *Very Suitable*

**How suitable do you think this treatment would be for treating difficulty staying asleep during the night?**

*Not at all Suitable* _____ *Very Suitable*

**How effective do you believe this treatment would be in the short term?**

*Not at all Effective* _____ *Very Effective*

**How effective do you believe this treatment would be for producing a permanent cure?**

*Not at all Effective* _____ *Very Effective*

**In addition to improving sleep, how effective would this treatment be for improving other aspects of your daytime functioning (e.g., alertness, performance, mood)?**

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**INSOMNIA QUESTIONNAIRE**

*Not at all* _____ *Very*
*Effective* *Effective*

**To what extent would this treatment produce side effects?**

*Very strong* _____ *No*
*Side Effects* *Side Effects*