Quick Sleep Screen

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Name_____ Date_____
Instructions: This scale should not normally be repeated. Circle the appropriate answer (number) that best agrees with your symptoms.
Date of Birth_____ Collar size (if known): _____inches.
Weight _____lbs; Height: _____

1. I feel sleepy in many daily activities…
1 2 3 4 5
disagree agree extremely
extremely

2. I have trouble going to sleep a great deal of the time.
1 2 3 4 5
disagree agree extremely
extremely

3. I have trouble staying asleep during the night a great deal of the time.
1 2 3 4 5
disagree agree extremely
extremely

4. I kick my legs during my sleep a great deal of the time.
1 2 3 4 5
disagree agree extremely
extremely

5. I snore so loudly that people complain.
1 2 3 4 5
disagree agree extremely
extremely

6. People have told me that I stop breathing in my sleep.
1 2 3 4 5
disagree agree extremely
extremely

7. I act out my dreams during sleep.
1 2 3 4 5
disagree agree extremely
extremely

Have you ever had a Sleep study before? _____
When/Where? _____
_____