Name: _____ Date (DD/MM/YY): _____
(PLEASE PRINT)

D.O.B. (DD/MM/YY): _____ Gender: _____

In-depth Sleep Assessment

1. What is the main reason for your visit today?

_____

2. On a scale of 1-10, 10 being the best, please rate your satisfaction with your sleep.

_____

3. What time do you go to bed?

_____

4. How long does it take for you to fall asleep?

_____

5. When do you wake up in the morning?

_____

6. Do you wake up throughout the night? If so, how many times?

   Total Hours of Sleep on average per night: ____

7. Do you feel refreshed when you wake up in the morning?

_____

8 . Do you feel the need to take a nap at any point in the day?

_____

9. Have you been involved in an accident in your lifetime?

_____

10. Have you had any of the following medical problems? (Check all that apply)

_____

- Angina
- Asthma
- Arthritis
- Back Problems
- Coronary Artery Bypass Surgery
- Chronic Fatigue Syndrome
- Diabetes
- Emphysema
- Fibromyalgia Syndrome
- Head Trauma
- Heartburn
- Heart Disease
- Hypertension
- Kidney or Liver Disease
- Leg Cramps While Asleep
- Loss of Consciousness
- Migraines
- Parkinson's Disease
- Post-Nasal Drip
- Depression
- Anxiety
- Seizures
- Stroke
- Hyperthyroidism
- Hypothyroidism

11. Do you take any herbal remedies? If so, how often?

12. On average, how much caffeine do you intake a day?

13. On average, how much alcohol do you intake a day?

14. Do you presently smoke cigarettes and/or use any recreational drugs?

15. Do you have any allergies?

16. Have you had any surgeries in the past?

17. Describe what a typical day of your diet would be. *

Note:

Sleep Consultant, SleepMed Corp.