SLEEP Questionnaire

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Patient: ___________________________ **Date of Birth:**___________

Today's Date: _______________________

Please describe the sleep problems: ____

Age of onset: ____

Typical Bed-Time: ____

Activity prior to/while in bed? ____

Typical Time of Sleep Onset: ____

Typical Time awakens in the morning ____

Please Calculate Duration of sleep: ________ hours

Are there awakenings at night: ☐No ☐Yes: How many? ________

What happens? ____

Is There Bed-Wetting? ☐No ☐Yes: How often? ________

Are there movements at night: ☐No ☐Yes: How many? ________

What happens? ____

What Medicines has she/he taken for the movements? ☐None ☐Can't remember name

Meds? ____

Does anything help? ☐No ☐Yes: ______________________________

Does anything worsen it? ☐No ☐Yes: ______________________________

What tests have been done? ☐None ___________________________________

Do you have a video of movements? ☐Yes ☐No ☐Not Applicable

Can you obtain a video? ☐Yes ☐No ☐Not Applicable