

SLEEP Questionnaire

Patient: _____ Date of Birth: _____ Today's Date: _____

Please describe the sleep problems in your own words:

Age of onset: _____

Typical Bed-Time: _____

Typical Time of Sleep Onset: _____

Typical Time of Morning Awakening: _____

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

Does anything help? 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