

SLEEP QUESTIONNAIRE FOR ADULTS

and children aged 11+ years

Some of the questions in this questionnaire ask about things that may happen whilst you are asleep (and of which you yourself would be unaware). Therefore, if possible, please complete this questionnaire with the help of someone who can comment on what you do when you are asleep (i.e. A sleeping partner/parent/friend etc.)

PART ONE

We would be grateful of the following general information:

Name.....

Date of birth.....

Address.....

.....

.....

Home phone number / contact number.....

Email address:

General practitioner details:

.....

.....

Height..... Weight.....

Date questionnaire completed.....

Have you had any excessive weight gain / weight loss in the last six months? YES NO

Please describe.

Give name of any medical disease or illness which you have at present or have had in the last month

Details of any treatment or medication which you are currently taking (including sleeping medication) or have had in the last month

Have you any history of epilepsy / convulsions / fits / seizures?
Please describe. YES NO

Do you have frequent coughs, colds, or allergies? YES NO

Do you smoke cigarettes?
Please describe how many per day. YES NO

Do you take other substances (e.g. Cannabis)?
Please describe what and how often. YES NO

Do you drink caffeinated drinks (e.g. tea, coffee, cola)?
Please describe how many per day

Tea..... YES NO
Coffee.....
Cola.....

What is your occupation?

What is your main sleep problem?

How long have you had it?

PART TWO

In this section we would like to know about your present sleeping habits. Your answers to the questions should be based on your sleeping habits during the LAST ONE MONTH only.

Please circle either YES or NO, tick one of the boxes or, where appropriate, write your answer.

1) How many other people sleep in the same room as you?

2) On average how long does it take you to fall asleep?

3) When you are in bed awake, what do you think about? Trying to fall asleep ()
Family matters ()
Work / college / school ()
Other (Please explain) ()

4) Do you do anything in bed to help you to get to sleep such as... Relaxation exercises ()
 Counting ()
 Lying still ()
 Reading ()
 Watching TV ()
 Listening to radio ()
 Using ear plugs ()
 Other (please explain) ()

5) How often do you have trouble getting off to sleep? Never ()
 Less than once a month ()
 About once a month ()
 Two to four times a month ()
 Many times a week ()
 Daily ()

6) What do you do if you can not sleep (e.g., get up, watch TV in bed, lie in the dark etc.)?

7) Do you get out of bed when you cannot sleep? YES NO

8) If you get out of bed what do you do once you are up?

9) Do you get annoyed / angry when you cannot sleep? YES NO

10) Before you fall asleep at night do your legs feel achy? YES NO

11) Do you have to move them about in bed? YES NO

12) Do you have to get out of bed to ease your aching legs? YES NO

13) How often do you wake in the night? Never ()
 Less than once a month ()
 About once a month ()
 Two to four times a month ()
 Many times a week ()
 Daily ()

14) If you usually wake in the night,
 how many times do you usually wake each night?

- 15) How long does it usually take to fall asleep again? Few minutes ()
 Up to half an hour ()
 Up to one hour ()
 One – two hours ()
 More than two hours ()

16) What do you do before getting back to sleep again (e.g. go to the toilet, watch TV, read etc)?

17) Do you ever sleep in unusual positions? YES NO
 If YES please describe.

18) If you sleep poorly how does it affect you the next day? Please describe.

19) Does a poor night's sleep make you...

- ... Depressed? YES NO
 ... Anxious? YES NO
 ... Irritable? YES NO
 ... Tired? YES NO

20) Does a poor night sleep affect your...

- ... Concentration? YES NO
 ... Memory? YES NO
 ... Ability to work? YES NO

21) How long would you like to sleep for each night?

22) How long do you think normal people of your age sleep for each night?

PART THREE

Some people sleep differently during the week than on weekends or holidays. Please answer the following questions about how you have been sleeping during the weekdays and also at weekends/holidays. Please write your answer or circle YES or NO. Base your answers on your sleep over the LAST ONE MONTH. If there is no difference between your sleep on weekdays and weekends/holidays then just fill in the column marked “Weekdays”.

	Weekdays	Weekends or Holidays
1) What time do you start getting ready for bed?		
2) What time do you usually go to bed?		
3) What time do you usually go to sleep?		
4) What time do you usually wake up?		
5) What time do you usually get up?		
6) Do you have to be woken in the morning (by someone else, an alarm clock etc)?	YES NO	YES NO
7) Do you usually wake up in the morning well rested?	YES NO	YES NO
8) Do you usually wake up in the morning feeling quite tired?	YES NO	YES NO
9) Do you usually wake up in a bad mood?	YES NO	YES NO
10) Do you usually wake up in a good mood?	YES NO	YES NO
11) Do you take naps during the day?	YES NO	YES NO
If YES, about what time do you nap and for how long?		

PART FOUR

During the LAST ONE MONTH have you shown any of the following behaviours? Please tick the box which describes how often each behaviour happens (it may be useful to ask your sleeping partner, if you have one, to help you fill in these questions since you may not know about some of the things that you do during your sleep).

Description	Don't know	Never	About once a month or less	A few times a month	Once or twice a week	3 – 6 times a week	Daily
Talking in sleep							
Walking in sleep							
Grinding teeth in sleep							
Banging head at night							
Quick movements of arms or legs during sleep (e.g. kicking, jumping, arm flailing)							
Moving around a lot in bed during sleep (restless sleep)							
Biting tongue during sleep							
Snoring loudly during sleep							
Gagging, choking, or snorting loudly during sleep							
Seem to repeatedly stop breathing for periods of time lasting up to 30 seconds during sleep							
Getting up to use the toilet in the night							
Wetting bed during sleep							
Waking in night complaining of nightmares or frightening dreams and feel quite anxious. This usually happens in the last half the night							
Waking during the night screaming in terror. Anxiety may be so bad that sweating, gasping or trembling may happen. This usually happens during the first half of the night. Not aware of surroundings and will not remember it the next day.							
Not wanting to go to bed because you are afraid.							

Description	Don't know	Never	About once a month or less	A few times a month	Once or twice a week	3 – 6 times a week	Daily
Fearing that if you go to sleep you might die							
Afraid of the dark							
Aching legs / leg cramps							
Insisting on bedtime rituals (e.g. Doing certain things in a special certain order) before sleep							
Needing sleeping medication							
During the day, muscles become so weak that you fall to the ground or have to lie down before falling (usually after laughing, crying or being frightened)							
Upon waking or going off to sleep, feeling paralysed even though you are aware of your surroundings							
During the day, have urges to go to sleep and cant stop yourself							
Feeling drowsy during the day, but can stop yourself from sleeping							
During the day, appearing more active than other people							
Rolling from side to side rhythmically in sleep or while going off to sleep							
Sleeping with head tipped right back							
Breathing through mouth rather than nose when asleep							
Complaining of headaches on waking up							
Sweating a lot during sleep							
Pain interfering with sleep							
Waking in the morning before 5am and staying awake.							

PART FIVE

This section asks some questions about the family's sleep and also treatments for sleep problems you might have tried. Please circle either YES or NO and, where appropriate, write your answer.

- 1) Have you ever had any advice or treatment for your sleep? YES NO
If YES, please describe.
- 2) Was this advice or treatment helpful? YES NO
- 3) How severe do you consider your sleep problems to be? Mild ()
Moderate ()
Severe ()
- 4) Are other members of the family affected by your sleep pattern? YES NO
Please describe who and how they are affected.
- 5) Has anyone on either side of the family had any sleep problems (e.g. Nightmares, sleepwalking, night terrors, unusual jerks, or movements, or other attacks)? If so, please describe and state their relationship to you.
- 6) Is there anything else about your sleep, or anything else, that you think is important and we have not mentioned? Please give details below.

Thank you very much for completing this questionnaire

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