Med*Sleep*

Welcome to MedSleep

This questionnaire package has been carefully designed to provide your sleep doctor with the most important information regarding your sleep problem. Although not all questions may seem relevant to your situation, all of this information helps the doctor determine an accurate diagnosis and effective treatment plan. Our aim is to provide you with the highest level of patient care, and this questionnaire is just the start of that process.

NAME

CONSULTATION AND/OR SLEEP STUDY DATE AND TIME

CLINIC LOCATION

If you find it necessary to cancel your appointment, please call us, as we require at least two business days advanced notification. Since missed appointments are not a provincial medicare insured service, you will be billed personally should you fail to provide the above notification.

ACKNOWLEDGMENT AND CONSENT TO EMAIL COMMUNICATIONS

This consent is optional. You are not required to communicate with MedSleep via email. Your refusal or withdrawal of this consent will in no way affect the care or treatment that you receive at MedSleep.

MedSleep offers its patients the option of communicating with MedSleep by email. Although we use reasonable means to protect the confidentiality of information sent and received by MedSleep email accounts, we cannot guarantee the confidentiality of email messages – in part due to the following risks (among other risks):

- Email messages can be misdirected to, or intercepted by, unintended and unknown recipients
- Email messages can be easier to falsify than other types of communication
- Organizations may have a legal right to access or retain email messages that pass through their systems.

If you wish to communicate with MedSleep via email, you must agree to the following:

- If your email message requires or invites a response from MedSleep and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether your message was received by MedSleep.
- You are not to use email to communicate medical emergencies, time-sensitive matters, or sensitive health information about: sexually transmitted disease; AIDS/HIV; mental health; or substance abuse.
- Email messages may be included in your medical record and accessible to MedSleep staff involved in the delivery and administration of your care.
- MedSleep will not forward email messages to third parties (including your family), without your prior written consent, except as authorized or required by law.
- You must inform MedSleep of any changes in your email address.
- MedSleep is not responsible for information loss due to technical failures associated with your software or Internet service provider, or the Internet in general.
- You are responsible for the confidentiality and security of the device on which you send or receive email messages. You should not send or receive emails on an employer's or other third party's device or via your employer's network.
- Although encryption software is recommended for email communications, email communications with MedSleep may not be encrypted.
- You may withdraw your consent to email communications at any time by providing written notice to MedSleep. MedSleep may withdraw the option of email communications at any time by providing written notice to you.

Patient Acknowledgment and Consent

I acknowledge that I have read, fully understand, and agree to the risks and conditions for email communications with MedSleep, noted above.

Name: ______________________ Signature: ______________________

Date: ______________________

IMPORTANT NOTE ON FILLING IN THIS FORM

a) COMPLETE USING A COMPUTER

1) This file is a "fillable" pdf. It can be completed using a computer.

2) First, save/download the form to your hard drive. Do not complete the form while it is still an attachment inside your email or browser: that software may cause odd behaviours that interfere with successful completion of the form.

3) Open the pdf using Acrobat Reader. Other softwares may – or may not – handle the fillable features correctly. Double click on the file's icon or open Reader and navigate to where you saved the file. (Search for "MedSleep-Intake-Form")

   Acrobat Reader is pre-installed on most computers. To install a free version or update to the most recent version, see here: http://get.adobe.com/reader/

4) Each area to enter a response is called a "field".
   - To begin, click inside the first field (the area above "Name" on page 1) and begin typing.
   - To advance to the next field, press the "tab" key or click in the field.
   - To complete a check box reply, press the space bar (on some systems, the "enter" key will also work).
   - To change an entry, click in the field you wish to amend.

5) From time to time, save the file as you go along.

6) Email the completed form to the clinic or bring the pdf file in person. To see the MedSleep contact list on the last page of this pdf - click here ».

b) COMPLETE BY HAND

If you prefer, or if there is difficulty with the computer input for any reason, you may complete the form by hand. Print this pdf – preprinted forms are also available from the clinic. Return or mail the completed form to the clinic. You could also scan and email the file.

c) DIGITAL SIGNATURE (for consent on page 1)

- Click the "Sign" tab (top right) of pdf window.
- Choose "I need to sign" section.
- Choose one of :
  - "type my signature"
  - "draw my signature "(to use mouse, digital pen or touch screen to sign) OR
  - "use an image" (to place a scan of your signature from your hard drive saved as jpg, png, tif or pdf).

PERSONAL INFORMATION

Name ______________________________
(LAST NAME, FIRST NAME)

Date ______________________________
(DD/MM/YYYY)

Date of Birth ______________ Age ________
(DD/MM/YYYY)

Male ☐ Female ☐ Marital Status ________

Street Address ______________________________

____

City ______________________________

Province ____________ Postal Code ________

Email ______________________________
☐ PERMISSION TO EMAIL

Home ______________________________
☐ PERMISSION TO LEAVE A MESSAGE

Cell ______________________________
☐ PERMISSION TO LEAVE A MESSAGE

Work ____________________ ext. ______
☐ PERMISSION TO LEAVE A MESSAGE

Occupation ______________________________

Employer ______________________________

Height: ________ feet ________ inches

Weight: ________ lbs ________ kgs

Neck Size ________

Health Card No. ______________________________

Version Code ____________ (IF APPLICABLE)

Referring Physician ______________________________

Family Physician ______________________________

Other Health Care Providers that you would like us to send a copy of information to: (CLINIC NAME, EMAIL, PHONE NUMBER)

1)

2)

3)

Consent for Participation in Clinical Research Database

From time to time, MedSleep group of clinics is involved in clinical research trials involving novel treatments for sleep disorders. MedSleep is seeking your consent to collect personal health information from you for inclusion in our clinical research database, so that we may contact you with information regarding clinical research trials that we are involved with now or may be involved with at a later date. Occasionally we compile data from the questionnaires for research projects. You will not be identified in any way, as this is grouped data.

You can refuse to sign this consent form. You can also withdraw your consent any time by writing to us with your request. Your refusal or withdrawal of consent will in no way affect the care or treatment that you receive at MedSleep.

Patient Consent

I authorize the MedSleep to collect my personal health information for inclusion in their Clinical Research Database.

Name ______________________ Signature ______________________ Date ____________

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A | SLEEP PROBLEMS

1. **Please check all that apply:**
   - ☐ Snoring
   - ☐ Gasping/choking/noted pauses in breathing
   - ☐ Difficulty falling asleep
   - ☐ Difficulty staying asleep
   - ☐ Fatigued/sleepy during the day
   - ☐ Shift work related problems
   - ☐ Unusual behaviour(s) during sleep (walking, talking, etc.)
   - ☐ Restless legs
   - ☐ Other (specify): ______________________

2. **Please describe the reason for your visit:**

3. **How long have you had these problems?**

4. **What treatments (including medications) have you tried to improve your sleep and was it helpful?**

5. **Are you aware of anything that triggered your sleeping problems?**

   ☐ Yes ☐ No

   If yes, please explain

6. **Have you had a sleep study or evaluation before?**

   ☐ Yes ☐ No

   If yes, where and when?

B | GENERAL HEALTH HISTORY

1. **Have you ever been diagnosed with any of the following?** PLEASE CHECK ALL THAT APPLY

   - ☐ Thyroid problems
   - ☐ Kidney disease
   - ☐ Liver disease
   - ☐ Diabetes
   - ☐ Arthritis
   - ☐ Heart problems
   - ☐ Hypertension (high blood pressure)
   - ☐ Head injury
   - ☐ Stroke
   - ☐ Migraine headaches
   - ☐ Seizures/epilepsy
   - ☐ Depression/bipolar disorder
   - ☐ Anxiety/panic disorder
   - ☐ Schizophrenia
   - ☐ Emphysema/COPD
   - ☐ Environmental/seasonal allergies
   - ☐ Reflux
   - ☐ Frequent urination
   - ☐ Iron deficiency
   - ☐ Anemia
   - ☐ Chronic pain
   - ☐ Nasal congestion
   - ☐ Asthma
   - ☐ Nasal trauma (broken nose)
   - ☐ Deviated septum

2. **Any other major medical conditions / major surgeries?**

B | GENERAL HEALTH HISTORY

3. Are there any significant sources of stress currently? ☐ Yes ☐ No

If yes, please explain what the sources of stress are:

4. If you have seen a psychologist or psychiatrist, or had problems with anxiety and depression, please describe briefly:

5. Please list any medications, vitamins, herbs and supplements that you are currently taking. Please include both prescription and over-the-counter medications.

CURRENT MEDICATION	DOSAGE	FREQUENCY	REASON	DATE STARTED

6. Please describe any medication allergies or other adverse reactions to medications. ☐ None

C | FAMILY MEDICAL HISTORY

1. Please put a checkmark in the proper column (right) where one of the following items applies to a member of your family:

	SON	DAUGHTER	BROTHER	SISTER	FATHER	MOTHER	OTHER
a) Sleep walking	☐	☐	☐	☐	☐	☐	☐
b) Screaming during sleep	☐	☐	☐	☐	☐	☐	☐
c) Very loud snoring in sleep	☐	☐	☐	☐	☐	☐	☐
d) Daytime sleepiness	☐	☐	☐	☐	☐	☐	☐
e) Other sleep problems PLEASE SPECIFY							
1)	☐	☐	☐	☐	☐	☐	☐
2)	☐	☐	☐	☐	☐	☐	☐
3)	☐	☐	☐	☐	☐	☐	☐
f) Fibromyalgia/chronic fatigue	☐	☐	☐	☐	☐	☐	☐
g) Epilepsy	☐	☐	☐	☐	☐	☐	☐
h) Depression	☐	☐	☐	☐	☐	☐	☐
i) Anxiety	☐	☐	☐	☐	☐	☐	☐
j) Other psychiatric illness	☐	☐	☐	☐	☐	☐	☐
k) Psychiatric treatment	☐	☐	☐	☐	☐	☐	☐
l) Death during sleep	☐	☐	☐	☐	☐	☐	☐

CHRONIC DISEASES

	SON	DAUGHTER	BROTHER	SISTER	FATHER	MOTHER	OTHER
m) Cancer	☐	☐	☐	☐	☐	☐	☐
n) Heart disease	☐	☐	☐	☐	☐	☐	☐
o) Rheumatoid arthritis	☐	☐	☐	☐	☐	☐	☐
p) Diabetes	☐	☐	☐	☐	☐	☐	☐
q) Other: PLEASE SPECIFY							
1)	☐	☐	☐	☐	☐	☐	☐
2)	☐	☐	☐	☐	☐	☐	☐
3)	☐	☐	☐	☐	☐	☐	☐

D | SLEEP SCHEDULE

1. What time do you get into bed?

Work days ___________ ☐ AM ☐ PM

Non-work days _______ ☐ AM ☐ PM

2. What time do you turn off the lights to go to sleep?

Work days ___________ ☐ AM ☐ PM

Non-work days _______ ☐ AM ☐ PM

3. On average, how long does it take you to fall asleep?

_____ minutes

4. What time do you get out of bed in morning?

Work days ___________ ☐ AM ☐ PM

Non-work days _______ ☐ AM ☐ PM

5. How often do you wake up in the middle of the night?

☐ 1-2 ☐ 2-4 ☐ 4-6 ☐ 6-8

6. How many hours do you actually spend in bed?

______ hours

7. How many hours do you estimate you actually sleep?

_____hours

8. How many days per week do you nap?

☐ 0 days ☐ 1-2 days ☐ 3-6 days ☐ Daily

If you do nap, for how long?

_____hours _____minutes

Are your naps refreshing?

☐ Yes ☐ No

9. Do you have a bed partner who can observe your sleep?

☐ Regularly ☐ Sometimes ☐ Rarely ☐ Never

☐ If you have a bed partner, please ask your bed partner to complete SECTION N on page 12

10. If you go to bed later, is it easier to fall asleep?

☐ Yes ☐ No

11. I have always been a night owl.

☐ Yes ☐ No

E | GENERAL HABITS

1. Please describe your predominant work schedule:

☐ Day Shift Hours: start _____ finish _____
☐ Night Shift Hours: start _____ finish _____
☐ Evening Shift Hours: start _____ finish _____
☐ Variable Schedule Hours: start _____ finish _____
☐ Unemployed
☐ Retired

2. How many days per week do you exercise 30 minutes or more?

☐ 0 days ☐ 1-2 days ☐ 3-4 days ☐ 5-7 days

3. On average, how many caffeinated beverages do you have per day? ____________

4. When do you usually drink your last caffeinated beverage?

☐ Before noon ☐ Before 4pm
☐ Before 8pm ☐ Close to bedtime

5. Do you regularly eat chocolate?

☐ Yes ☐ No ***If yes, how much?*** _________

6. Do you smoke cigarettes?

☐ Yes ☐ No

If yes, how many packs per day?

☐ Less than ½ a pack ☐ ½ a pack
☐ 1 pack ☐ 2 packs or more

If no, have you ever smoked?

☐ Yes ☐ No

7. On average, how many alcoholic beverages do you have each week? _________

8. Have you ever used street/recreational drugs regularly?

☐ Yes ☐ No

If yes, what? ______________________________

____

☐ Current ☐ Past: from ~ age ____ to ____

F | BEFORE SLEEP

Please answer the following questions with respect to the last 30 days

1. How often do you use medication or alcohol to help you fall asleep?

- ☐ Never
- ☐ 3-5 times a week
- ☐ 1-2 times a month
- ☐ Every night
- ☐ 1-2 times a week

2. Which of the following do you notice when you try to fall asleep?

	ALWAYS	OFTEN	RARELY	NEVER
a) Anxiety, tension, worry or disturbing thoughts	☐	☐	☐	☐
b) Difficulty breathing or feeling suffocated	☐	☐	☐	☐
c) Pain	☐	☐	☐	☐
d) See and/or hear things that do not really exist	☐	☐	☐	☐
e) A feeling of dread	☐	☐	☐	☐
f) Planning or problem solving	☐	☐	☐	☐

3. Do you have a strong urge to move your legs while sitting or lying down?

☐ Yes ☐ No

If yes, please answer the following 5 questions:

a) Is this sensation worse when you are sitting or lying down than when you are moving around or walking?

☐ Yes ☐ No

b) Does this sensation improve if you get up, stretch your legs or walk?

☐ Yes ☐ No

c) Is this sensation worse in the evening/night than in the morning/afternoon?

☐ Yes ☐ No

d) Does this sensation interfere with your sleep?

☐ Yes ☐ No

e) How often does this sensation occur?

☐ 2-4 times/month ☐ 2-3 times/week
☐ 4-5 times/week ☐ 6-7 times/week

G | DURING SLEEP

1. Has anyone ever told you or have you noticed that you:

	FREQUENTLY	OCCASIONALLY	NEVER	DON'T KNOW
a) Grind your teeth during sleep	☐	☐	☐	☐
b) Sleepwalk, wake up screaming or eat while asleep	☐	☐	☐	☐
c) Kick or twitch your legs during sleep	☐	☐	☐	☐
d) Act out your dreams	☐	☐	☐	☐
e) Talk in your sleep	☐	☐	☐	☐
f) Snore	☐	☐	☐	☐

2. Has anyone ever told you or have you noticed that you:

	FREQUENTLY	OCCASIONALLY	NEVER	DON'T KNOW
a) Have recurrent distressing dreams	☐	☐	☐	☐
b) Watch the clock when unable to sleep	☐	☐	☐	☐
c) Have significant nasal congestion	☐	☐	☐	☐

3. If you wake up, what awakens you? *Please describe.*

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G | DURING SLEEP

4. What do you do when you are awake at night?

- ☐ Stay in bed
- ☐ Read/watch TV
- ☐ Go to another room to relax
- ☐ Try to sleep elsewhere
- ☐ Walk around
- ☐ Work or clean

5. How long does it take you to fall back to sleep?

_______ minutes

6. I keep a TV, computer or smart phone in the bedroom.

☐ Yes ☐ No

H | BERLIN QUESTIONNAIRE

CATEGORY 1

1. Do you snore?

☐ Yes ☐ No ☐ Don't know

2. If you snore, your snoring is:

- ☐ Slightly louder than breathing
- ☐ As loud as talking
- ☐ Louder than talking
- ☐ Very loud, can be heard in adjacent rooms

3. How often do you snore?

- ☐ Nearly every day
- ☐ Three to four times a week
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Never or nearly never

4. Has your snoring ever bothered other people?

☐ Yes ☐ No ☐ Don't know

5. Has anyone noticed that you quit breathing during sleep?

- ☐ Nearly every day
- ☐ Three to four times a week
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Never or nearly never

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CATEGORY 2

6. How often do you feel tired or fatigued after your sleep?

- ☐ Nearly every day
- ☐ Three to four times a week
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Never or nearly never

7. During your waking time, do you feel tired, fatigued, or not up to par?

- ☐ Nearly every day
- ☐ Three to four times a week
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

☐ Yes ☐ No

If yes, how often does this occur?

- ☐ Nearly every day
- ☐ Three to four times a week
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Never or nearly never

CATEGORY 3

9. Do you have high blood pressure?

☐ Yes ☐ No ☐ Don't know

I | AWAKE TIME

1. How do you feel when you wake up in the morning?

	ALWAYS	OFTEN	RARELY	NEVER
a) Tired, want to continue sleeping	☐	☐	☐	☐
b) Suffer from pains or stiffness	☐	☐	☐	☐
c) Unpleasantly dry mouth	☐	☐	☐	☐
d) Headache	☐	☐	☐	☐
e) Heartburn	☐	☐	☐	☐

2. How often does your sleep problem interfere with your work/home functioning (daily chores, concentration, memory, driving, etc.)?

☐ Always ☐ Often ☐ Rarely ☐ Never

3. As a result of sleepiness, have you experienced any of the following?

☐ Auto accident
☐ Poor work performance or work related injury
☐ Reduction in quality of life
☐ None of these

J | SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

1. **Choose the most appropriate answer for each situation:**

CHANCE OF DOZING:	HIGH	MODERATE	SLIGHT	WOULD NEVER
a) Sitting and reading	☐	☐	☐	☐
b) Watching TV	☐	☐	☐	☐
c) As a passenger in a car for an hour without a break	☐	☐	☐	☐
d) Sitting inactive in a public place (theatre, meeting)	☐	☐	☐	☐
e) Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f) In a car while stopped for a few minutes in traffic	☐	☐	☐	☐
g) Sitting quietly after lunch without alcohol	☐	☐	☐	☐
h) Sitting and talking to someone	☐	☐	☐	☐

2. When you are laughing, surprised or angry, do your muscles become weak (jaw drooping, leg buckling or falling down)?

☐ Yes ☐ No

3. How often do you stop an activity because of an irresistable urge to sleep?

☐ Never ☐ Sometimes ☐ Often

4. Have you ever been paralyzed (unable to move all of your muscles) for a short time when you first awaken or first go to sleep?

☐ Yes ☐ No

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K | SLEEP HEALTH HISTORY

1. Which of these sleep disorders have you ever been diagnosed with or treated for?
PLEASE CHECK ALL THAT APPLY

- ☐ No previous diagnosis
- ☐ Restless Legs Syndrome
- ☐ Obstructive Sleep Apnea
- ☐ Periodic Limb Movement Disorder
- ☐ Central Sleep Apnea
- ☐ Insomnia
- ☐ Narcolepsy/Hypersomnolence
- ☐ Other ______________________

2. If you've had sleep apnea treatment, what sort of treatment did you have? PLEASE CHECK ALL THAT APPLY

- ☐ CPAP
- ☐ Dental appliance
- ☐ Surgery
- ☐ Positional therapy, diet or exercise

3. Have you ever been diagnosed with insomnia?

☐ Yes ☐ No

If yes, what treatment have you received?

L | QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (QIDS-SR 16)

Please check the one response to each item that best describes you for the past seven days.

1. Falling asleep

- ☐ I never take longer than 30 minutes to fall asleep
- ☐ I take at least 30 minutes to fall asleep, less than half the time.
- ☐ I take at least 30 minutes to fall asleep, more than half the time.
- ☐ I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep during the night

- ☐ I do not wake up at night.
- ☐ I have a restless, light sleep with a few brief awakenings each night.
- ☐ I wake up at least once a night, but I go back to sleep easily.
- ☐ I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking up too early

- ☐ Most of the time, I awaken no more than 30 minutes before I need to get up.
- ☐ More than half the time, I awaken more than 30 minutes before I need to get up.
- ☐ I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
- ☐ I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping too much

- ☐ I sleep no longer than 7–8 hours/night, without napping during the day.
- ☐ I sleep no longer than 10 hours in a 24-hour period including naps.
- ☐ I sleep no longer than 12 hours in a 24-hour period including naps.
- ☐ I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling sad

- ☐ I do not feel sad.
- ☐ I feel sad less than half the time.
- ☐ I feel sad more than half the time.
- ☐ I feel sad nearly all of the time.

6. Decreased appetite

- ☐ There is no change in my usual appetite.
- ☐ I eat somewhat less often or lesser amounts of food than usual.
- ☐ I eat much less than usual and only with personal effort.
- ☐ I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

L | QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (QIDS-SR 16)

Please check the one response to each item that best describes you for the past seven days.

7. Increased appetite

- ☐ There is no change from my usual appetite.
- ☐ I feel a need to eat more frequently than usual.
- ☐ I regularly eat more often and/or greater amounts of food than usual.
- ☐ I feel driven to overeat both at mealtime and between meals.

8. Decreased weight (within the last two weeks)

- ☐ I have not had a change in my weight.
- ☐ I feel as if I've had a slight weight loss.
- ☐ I have lost 2 pounds or more.
- ☐ I have lost 5 pounds or more.

9. Increased weight (within the last two weeks)

- ☐ I have not had a change in my weight.
- ☐ I feel as if I've had a slight weight gain.
- ☐ I have gained 2 pounds or more.
- ☐ I have gained 5 pounds or more.

10. Concentration/decision making

- ☐ There is no change in my usual capacity to concentrate or make decisions.
- ☐ I occasionally feel indecisive or find that my attention wanders.
- ☐ Most of the time, I struggle to focus my attention or to make decisions.
- ☐ I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of myself

- ☐ I see myself as equally worthwhile and deserving as other people.
- ☐ I am more self-blaming than usual.
- ☐ I largely believe that I cause problems for others.
- ☐ I think almost constantly about major and minor defects in myself.

12. Thoughts of death or suicide

- ☐ I do not think of suicide or death.
- ☐ I feel that life is empty or wonder if it's worth living.
- ☐ I think of suicide or death several times a week for several minutes.
- ☐ I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General interest

- ☐ There is no change from usual in how interested I am in other people or activities.
- ☐ I notice that I am less interested in people or activities.
- ☐ I find I have interest in only one or two of my formerly pursued activities.
- ☐ I have virtually no interest in formerly pursued activities.

14. Energy level

- ☐ There is no change in my usual level of energy.
- ☐ I get tired more easily than usual.
- ☐ I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework,cooking or going to work).
- ☐ I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down

- ☐ I think, speak, and move at my usual rate of speed.
- ☐ I find that my thinking is slowed down or my voice sounds dull or flat.
- ☐ It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
- ☐ I am often unable to respond to questions without extreme effort.

16. Feeling restless

- ☐ I do not feel restless.
- ☐ I'm often fidgety, wringing my hands, or need to shift how I am sitting.
- ☐ I have impulses to move about and am quite restless.
- ☐ At times, I am unable to stay seated and need to pace around

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M | GAD-7 SCREENING QUESTIONS

1. During the last two weeks, how often have you been bothered by the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
a) Feeling nervous, anxious or on edge	☐	☐	☐	☐
b) Not being able to stop or control worrying	☐	☐	☐	☐
c) Worrying too much about different things	☐	☐	☐	☐
d) Trouble relaxing	☐	☐	☐	☐
e) Being so restless that it is hard to sit still	☐	☐	☐	☐
f) Becoming easily annoyed or irritable	☐	☐	☐	☐
g) Feeling afraid as if something awful might happen	☐	☐	☐	☐

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2. If you checked off any problems in Question 1, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

3. Check all that apply:

- ☐ I have panic attacks or episodes of sudden fear
- ☐ I worry consistently about having attacks like this
- ☐ I avoid crowds or being away from home
- ☐ I have worried about many different things on more than half the days in the past six months
- ☐ I often feel anxious or nervous in social situations, such as parties
- ☐ I am frequently occupied with obsessive thoughts, preoccupations, or performing compulsive behaviours or rituals
- ☐ I have recurrent nightmares and flashbacks of past bad things that have happened to me

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N | BED PARTNER / OBSERVER QUESTIONNAIRE

This questionnaire should be filled out by the patient's bed partner regarding the sleep habits of the patient who will be seen in the Sleep Disorder Centre. It is important that the bed partner answer each question as completely and as accurately as possible.

1a. Name of the patient who will be seen in the Sleep Disorder Centre:

1b. Name / circumstance of person completing this:

2. Why is your spouse/partner being referred to the sleep clinic? What are your main concerns about their sleep, or how they function in the daytime?

3. During sleep, does he/she:

	DAILY	WEEKLY	MONTHLY	YEARLY	RARELY	NEVER
a) Snore?						
b) Stop breathing or breathe irregularly when sleeping?						
c) Wake up gasping or unable to breathe?						
d) Sweat a lot when sleeping?						
e) Have a headache when they wake up?						
f) Have nasal congestion?						
g) Breathe through their mouth when sleeping?						
h) Have pain or discomfort that interferes with sleep?						
i) Have a cough that disturbs their sleep? Or your sleep?						
j) Complain of gas, indigestion or heartburn?						
k) Grind their teeth in sleep?						
l) Have trouble keeping their legs still when sitting in the evening?						
m) Have trouble keeping their legs still when lying in bed?						
n) Kick frequently during sleep?						
o) Act out dreams?						
p) Sleepwalk?						
q) Have trouble waking up?						
r) Have trouble with sleepiness through the day or evening?						
s) Disturb your sleep?						

4. Describe what you checked off above in more detail: describe what happens, when it happens during their sleep, and how often you notice it. Please add any other information or concerns that might help.

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DEDICATED TO ACHIEVING EXCELLENCE

in both the diagnosis and treatment of the full spectrum of sleep disorders, providing comprehensive evaluation and integrative treatment.

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