Sleep Disorders Questionnaire

This questionnaire is a screening tool for Dr. Singh to assist their clinical evaluation of insomnia. It can be used to screen for a sleep disorder.

Grade your answer by circling one number for each of the following questions:		Grading Scale				
		Never	Rarely	Occasionally	Most Nights/Days	Always
1	Do you have trouble falling asleep?	1	2	3	4	5
2	Do you have trouble staying asleep?	1	2	3	4	5
3	Do you take anything to help you sleep?	1	2	3	4	5
4	Do you use alcohol to help you sleep?	1	2	3	4	5
5	Do you have any medical conditions that disrupt your sleep?	1	2	3	4	5
6	Have you lost interest in hobbies or activities?	1	2	3	4	5
7	Do you feel sad, irritable, or hopeless?	1	2	3	4	5
8	Do you feel nervous or worried?	1	2	3	4	5
9	Do you think something is wrong with your body?	1	2	3	4	5
10	Are you a shift worker or is your sleep schedule irregular?	1	2	3	4	5
11	Are your legs restless and/or uncomfortable before bed?	1	2	3	4	5
12	Have you been told that you are restless or that you kick your legs in your sleep?	1	2	3	4	5
13	Do you have any unusual behaviors or movements during sleep?	1	2	3	4	5

14	Do you snore?	1	2	3	4	5
15	Has anyone said that you stop breathing, gasp, snort, or choke in your sleep?	1	2	3	4	5
16	Do you have difficulty staying awake during the day?	1	2	3	4	5