Sleep Disorders Questionnaire

This questionnaire is a screening tool for physicians to assist their clinical evaluation of insomnia. It can be used to screen for a sleep disorder. See page 2 for guide to interpreting the questionnaire.

The physician should perform a more detailed clinical evaluation and/or refer to specialist when appropriate.

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 behaviours 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

See page 2 for guide to interpreting the questionnaire.

GUIDE TO INTERPRETING THE INSOMNIA SCREENING QUESTIONNAIRE

DIAGNOSTIC DOMAINS:

1) Insomnia: Q1-5
2) Psychiatric Disorders: Q6-9
3) Circadian Rhythm Disorder: Q10
4) Movement disorders: Q11-12
5) Parasomnias Q13

GENERAL GUIDELINES FOR INTERPRETING THE GRADING SCALE

1) Grading of 3, 4 or 5 on any question, the patient likely suffers from insomnia. If they answer 3, 4 or 5 for two or more items and have significant daytime impairment the insomnia requires further evaluation and management.
2) Grading 4 or 5 on questions 6-9 require further screening for psychiatric disorders. Question 8 refers to somatization and may reflect an underlying somatoform disorder which requires specific treatment.
3) Grading 4 or 5 on question 10 may be a circadian rhythm disorder. Further questioning about shift work or a preference for a delayed sleep phase should be done.
4) Grading 4 or 5 on question 11 or 12 is significant and likely contributing to the patient's symptoms of insomnia or non-restorative sleep. Question 11 refers to restless legs syndrome and question 12 refers to periodic limb movement disorder.
5) Grading 2-5 on question 14 should raise concern especially if the event or movement is violent or potentially injurious to the patient or bed partner.
6) Grading 4 or 5 on question 14 or 15 alone require further clinical evaluation for sleep apnea. Grading above 3 on questions 14 and 15 or 14 and 16 is also suspicious for sleep apnea and further evaluation should be done.

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

STOP-Bang questionnaire

☐ Yes	☐ No	**Snoring?** Do you **snore loudly** (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?
☐ Yes	☐ No	**Tired?** Do you often feel **tired, fatigued, or sleepy** during the daytime (such as falling asleep during driving)?
☐ Yes	☐ No	**Observed?** Has anyone **observed** you **stop breathing** or **choking/gasping** during your sleep?
☐ Yes	☐ No	**Pressure?** Do you have or are being treated for **high blood pressure?**
☐ Yes	☐ No	**Body mass index more than 35 kg/m^2?**
☐ Yes	☐ No	**Age older than 50 years old?**
☐ Yes	☐ No	**Neck size large? (measured around Adam's apple)** For male, is your shirt collar 17 inches or larger? For female, is your shirt collar 16 inches or larger?
☐ Yes	☐ No	**Gender = Male?**
Scoring criteria*:		
For general population		
Low risk of OSA: Yes to 0 to 2 questions		
Intermediate risk of OSA: Yes to 3 to 4 questions		
High risk of OSA: Yes to 5 to 8 questions		

OSA: obstructive sleep apnea

* For validated scoring criteria in obese patients, please refer to UpToDate topic on surgical risk and the preoperative evaluation and management of adults with obstructive sleep apnea.

References:

1. *Chung F, Yegneswaran B, Liao P, et al. STOP questionnaire: a tool to screen patients for obstructive sleep apnea. Anesthesiology 2008; 108:812.*
2. *Chung F, Subramanyam R, Liao P, et al. High STOP-Bang score indicates a high probability of obstructive sleep apnoea. Br J Anaesth 2012; 108:768.*

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Sleep efficiency: calculate "average" night

$\frac{\text{Total hr asleep}}{\text{Total time in bed}} = \square\%$. $(11-6) - 1\frac{1}{2} = 5.5$ $10:30 - 7 = 8.5$ $\frac{5.5}{8.5} = 65\%$. aim 85%

Sleep Diary

Please complete this form each morning when you wake up

DATE Which night is being reported on?							
Measuring the pattern of your sleep							
1. What time did you wake up this morning?	6:00						
2. What time did you rise from bed this morning?	7						
3. What time did you go to bed last night?	10:30						
4. What time did you put the light out?	10:40						
5. How long did it take you to fall asleep?	20min						
6. How many times did you wake in the night?	2x						
7. How long were you awake during the night?	90min. 1hr.						
8. How long did you sleep altogether?	6 hr.						
9. How much alcohol did you have last night?	~~0~~						
10. How many sleeping pills did you take?	~~0~~						
Measuring the quality of your sleep – for the last 2 questions, please answer using the scale below							
0 = not at all; 1 = slightly; 2 = moderately; 3 = quite a lot; 4 = very							
1. How well rested do you feel this morning?	0						
2. Was your sleep of good quality?	0						
Notes or comments							

Helpful tips for keeping the sleep diary:

- **Do:** Complete your diary within 1 hour of getting up
- **Do:** Try to write down times to the nearest 5 to 10 minutes
- **Do:** Double check your answers
- **Don't:** Clock watch during the night
- **Don't:** Worry about it. It's just a record of your sleep!
- **Don't:** Make up answers. It's OK to leave it blank if you forget

From Colin Espie "Overcoming insomnia and sleep problems" London Robinson, 2006

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Please complete this form each morning when you wake up

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Measuring the pattern of your sleep							
1. What time did you wake up this morning?							
2. What time did you rise from bed this morning?							
3. What time did you go to bed last night?							
4. What time did you put the light out?							
5. How long did it take you to fall asleep?							
6. How many times did you wake in the night?							
7. How long were you awake during the night?							
8. How long did you sleep altogether?							
9. How much alcohol did you have last night?							
10. How many sleeping pills did you take?							
Measuring the quality of your sleep – for the last 2 questions, please answer using the scale below							
0 = not at all; 1 = slightly; 2 = moderately; 3 = quite a lot; 4 = very							
1. How well rested do you feel this morning?							
2. Was your sleep of good quality?							
Notes or comments (naps?)							

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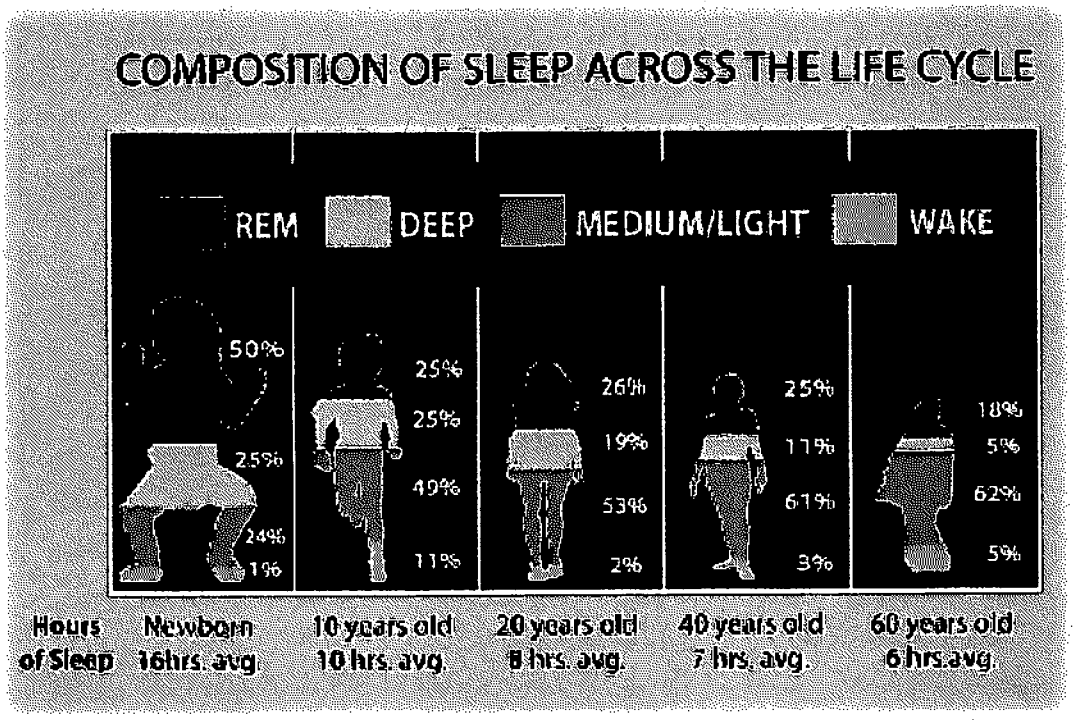

The size of the figure reflects the hours of sleep

Reference:
Driver H, Gottschalk R, Hussain M, Morin C, Shapiro C, Van Zyl L. Insomnia in Adults and Children. Joli Joco Publications Inc., 2012. http://css-scs.ca/images/brochures/Insomnia_Adult_Child.pdf Accessed May 16, 2016