Sleep Consultation Form

Date: _____/_____/_____

Client Details

Clients Name:_____

Address:_____

_____

Postcode:_____

Phone:_____ Alternative Phone:_____

D.O.B:_____ Age:_____ Gender:_____

Relationship Status: _____ Children (Ages):_____

Occupation: _____ Since when:_____

Emergency Contact Person:_____ Phone:_____

Relation to you:_____

General Practitioner:_____ Phone:_____

Permission to contact Yes / No

Religion/Cultural Considerations:_____

How did you hear about our Sleep Consulting services?_____

Presenting Sleep Issues and Behaviours

Average hours sleep per night:_____

Main Sleep Problem: (check all that apply) Snoring □ Sleepiness or feeling tired □ Difficulty falling asleep □ Breathing stops during the night □ Bed partner making you seek help □ Difficulty staying asleep during night □ Other: □ (If other, please describe):_____

I struggle mostly with: (please circle) Getting to sleep Staying asleep Waking up

Perceived cause:_____

Associated symptoms:_____

Aggravated / alleviated by:_____

Please check any of the following activities that you do in bed: Read □ Watch TV □ Eat □ Talk on the phone □ Listen to music □ Use computer □

How many pillows do you sleep with?_____

Is your bed and bedroom comfortable, dark and quiet? Yes □ No □

Do you do shift work or work during the night? Yes □ No □

Who do you live with/ sleep with?_____

What types of exercise do you do? How often?_____

When trying to fall to sleep, do you experience the following?: Trouble staying asleep □ Difficulty falling asleep □ Repeated awakenings □ Waking up too early □ Snoring or trouble breathing □ Choking or gasping for air □ Morning headaches □ Dry mouth □ Fall asleep at work □ Have others say you stop breathing at night □ Sleep talking □ Sleep walking □ Leg, arm or body jerks □ Tired or crampy legs when you awaken □ Unpleasant feeling in arms or legs just at night □ Kept awake because of bed partner □

When waking up from sleep, do you notice the following?: coughing or choking □ shortness of breath □ an irregular/ rapid heartbeat □ nasal congestion or runny nose □ stomach acid taste □ heart burn □ dry mouth □ headache anxious or panicky feeling □ legs, arms or body moving or jerking □ bed covers extremely messy □ momentary confusion □ vivid or frightening visual images □ temporarily unable to move your body □

During the day when you want to be alert and awake, do you experience: Feeling tired even after a full night's sleep □ Struggling to stay awake □ Difficulty concentrating □ Dozing off (even if for a second) □ Trouble remembering □ Stress, anxiety or sadness □ Avoiding social situations □ Not enjoying fun activities □ Daytime sleepiness □ Sudden muscular weakness with strong emotion □

Sleep-Wake Schedule

The below questions about sleep and wake schedules recognise patterns can vary from day to day. Do not worry about being exact, these are just your best estimates.

Do you keep a fairly regular schedule? Yes □ No □
What time do you go to bed?_____
What time do you get out of bed?_____
Once in bed how long does it take to fall asleep?_____
Once asleep, how many times do you wake up?_____
How much lost sleep from awakenings (in minutes)? _____
What usually cause you to wake up?_____
What time do you get out of bed to start the day?_____
Do you awaken refreshed and ready to begin the day? Always □ Almost always □ Sometimes □ Rarely □ Never □
How long does it typically take until you are fully awake (in minutes)?_____
How often do you take naps? Daily □ A few days a week □ A few days a month □ Rarely/Never □ If you nap, how long are your naps?_____
When you are free to choose your own schedule (vacations, weekends etc.), when do you prefer to go to sleep?_____
When do you prefer to wake-up?_____

Substances That Can Affect Sleep

Many commonly used substances can affect sleep. Please describe your use of the following over the last month.
Caffeinated beverages (including coffee, tea, sodas etc.) please list your daily consumption:_____
Alcoholic beverages (including wine, beer, liquor) please list your daily consumption:_____
Tobacco products (include cigarettes, cigars, snuff, chew etc) list your daily use:_____
Mood altering drugs including stimulants (such as cocaine, amphetamine), tranquilizers, and hallucinogens (including marijuana, LSD, or Ecstasy) can affect both sleep and daytime alertness. If you have tried such drugs please list and describe any effects on sleep or daytime alertness:_____

General Medical History

Do you currently have or have you ever been diagnosed with any of the following: High blood pressure □ Elevated cholesterol □ Diabetes □ Heart disease □ Lung disease □ Liver disease □ Heart attack □ Abnormal heart rhythm □ Kidney disease □ Head trauma or concussion □ Reflux (GERD) □ Neurologic disease □ Seizure disorder □ Immune disorder □ Kidney disease □ Thyroid disease □ Arthritis □ Stroke □ Fibromyalgia □ Depression □ Anxiety/ panic disorder □ Drug

abuse/dependence □ Alcoholism □

Please list any other health problems:_____

Please list the names of healthcare providers (or therapists of any kind) for whom you are currently receiving care, or have seen in the past year_____

Please describe any past surgeries or hospitalisations:_____

Please list the medications, vitamins, herbs, and supplements you have taken in the last month (Please include both prescription and over-the-counter medications):_____

Please describe any allergies, side effects or other adverse reactions to medications. If none please write in "none":_____

Medical Review of Symptoms: Do you experience any of the following? Headaches □ Shortness of breath □ Pain in muscles □ Vision problems □ Abdomen discomfort □ Pain in joints □ Nasal congestion □ Diarrhoea □ Skin problems □ Difficulty swallowing □ Constipation □ Feeling depressed □ Chest pain □ Blood in stools□ Feeling anxious □ Heart palpitations □ Urinary frequency □ Heart burn □ Wheezing □ Incontinence □ Coughing □ Erectile dysfunction □

Family Medical History

Please list blood relatives (parents, siblings, children etc.) who snore, have daytime sleepiness, insomnia, or other sleep problems:_____

Please list blood relatives with medical or psychiatric disorders:_____

Habits & Lifestyle

Main interests and hobbies:_____

Do you enjoy exercise & how often do you do it:_____

Do you smoke?_____ If yes, how long for? _____

Do you use recreational drugs? _____

Rate your energy between 1-10 (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Rate your stress levels between 1-10 (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Is there anything else you would like to share with your Sleep Consultant? _____

_____

I confirm that the above information is correct to the best of my knowledge. I accept that it is my responsibility to inform the consultant of any changes to my health or any of the above information. I understand the consultant will not be held responsible for any given advice and will not be liable for any alleged harm or ill health that may result at any time (before, during or after testing or consultation). I understand that advice given may be opinion and have little scientific proof. I will keep my GP informed of my health concerns and make sure he/she is aware I am consulting with a Sleep Consultant. Upon any changes in health, my GP will be notified immediately. I am aware that the consultant may refuse consultation if he/she feels it necessary.

Signature: _____ Date: _____