Sleep Balance Academy

Sleep Disorder Screening Form

1. Name : _____ _____ Date of Birth: _____ Age _____Male/Female

Are you overweight? **Yes 3/ No** Have you been observed to stop breathing, coughing, gasping sleeping ? **Yes 4/No** Is your neck size 15.5 inches or more for a female/ 17 inches or more for a male?**Yes2/No** (Circle each) If history of high blood pressure, heart disease, diabetes, thyroid disorder or stroke? **4Yes/No,** Do you have a CPAP **Y/N**, Not use your CPAP ?**6Yes/No** Do you have depression/irritability?**2 Yes/No** Smoke? **3 Yes/No** Receded Lower or Upper Jaw? **2Y/N** Do you awaken frequently at night to urinate? **2Y/N** **Total of Section 1 Scores**_____

_____

2. Epworth Sleepiness Scale: (Use the following scale to choose the most appropriate number for the situation)

0= would never doze 1= slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing with-**no caffeine**

Sitting and reading	0	1	2	3	
Sitting inactive in a public place	0	1	2	3	
As a passenger in a car for an hour with no break	0	1	2	3	
Lying down to rest in the afternoon when permitted	0	1	2	3	Epworth Score
Sitting and talking to someone*	0	1	2	3	_____
In a car while stopped for a few minutes	0	1	2	3	(If Epworth score is 7
Watching TV	0	1	2	3	up to 10 assign 3 Points
					if 11 + Assign 6 points)

3. Sleep, Spine, and Dental Questions:

Do you know or has anyone told you that you have loud or moderately loud snoring? No = 0 Yes = 4

Do you have forward neck posture or awake with morning headaches, jaw or neck pain? No= 0 Yes = 2

Do you grind your teeth? No= 0 Yes = 2

Total Score Sections 1.2.3. _____

Patient signature _____ Date _____

Patient phone number (mobile preferred) _____ Consulting Doctor _____ Phone_____

Total score of 7 or more should consider sleep study or referral.

Sleep studies can be ordered at www.onlinehomesleepstudy.com