



**COLORADO SPRINGS HEALTH PARTNERS, P.C.  
SLEEP CENTER**

1625 Medical Center Point, Suite 290  
Colorado Springs, CO 80907

Phone: 719-XXX-XXXX

Fax: 719-XXX-XXXX

***PLEASE BRING THIS WITH YOU TO YOUR STUDY.***

**PRE-SLEEP STUDY QUESTIONNAIRE**

**Please respond to the following questions as accurately as possible.**

NAME: \_\_\_\_\_ Date of Study \_\_\_\_\_

1. How many hours did you sleep last night? \_\_\_\_\_ hours
2. Did you feel rested upon awakening this morning? Yes No
3. Do you normally nap during the day? Yes No If yes, for how long? \_\_\_\_\_
4. On the average, how much caffeine do you consume a day?  
Coffee \_\_\_\_\_ cups Tea \_\_\_\_\_ cups Soda \_\_\_\_\_ cans
5. Are you sensitive or allergic to any types of tapes or adhesives? Yes No  
If yes, please explain: \_\_\_\_\_
6. Do you take sleep aides to help you go to sleep? Yes No  
If yes, what? \_\_\_\_\_
7. Do you take any medications to help you stay awake? Yes No  
If yes, what medication? \_\_\_\_\_
8. If you suffer from body pain that keeps you from sleeping, please describe:  
\_\_\_\_\_
9. Do outside noises keep you from falling to sleep? Yes No
10. Choose the statement below that best describes how you feel right now:  
\_\_\_\_\_ Alert and wide awake  
\_\_\_\_\_ Tired, but able to concentrate; could go to sleep.  
\_\_\_\_\_ Having difficulty staying awake; fighting sleep
11. Please give us any feedback about scheduling your appointment and feeling prepared for the study:  
\_\_\_\_\_  
\_\_\_\_\_

**Please bring this questionnaire with you to your study. Thank you!**