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!