Legacy Counseling Service, LLC / Dr. Melissa Leedy, Ph.D.
2498 W New Orleans, Broken Arrow OK 74011-1590
www.legacycounselingservices.com
539-777-1129

IMPORTANT INFORMATION – PLEASE READ CAREFULLY

Dear Client,

In this letter are some questions about your sleep and a sleep diary that we would like for you to fill out one week before your first appointment and bring with you to your first appointment. The questionnaires and the sleep diary will help us to know more about your sleep difficulties and treatment needs.
Please note the following:

1. The best way to track an irregular sleep-wake pattern is to **keep a daily sleep diary**. By filling out a sleep diary, we will learn a lot about your sleep-wake pattern. The sleep diary is short and will only take a couple of minutes to fill out each morning. It is important to fill out the diary as soon as you wake up in the morning. This is when you will best remember what happened during the night. Do not worry about remembering exactly what happened during the night. If you fill it out first thing in the morning, your best estimate will be most accurate. Do not fill it out during the night when you wake up. That will just make your sleep worse! You should try to keep the sleep diary for at least one week before your appointment and **bring it to your appointment**.

2. Please respond to the appointment text reminder so we know that you will be at the appointment time and date.

3. Please **arrive on time for your appointment,** if you are more than 10 minutes late for your appointment it may need to be rescheduled to avoid interfering with other client's appointments scheduled after you.

4. It is often helpful to share the information learned in treatment with spouses or other significant others.

5. **If you do not wish to keep this appointment**, **please call ahead of time**. You may call at any hour to cancel your appointment, please leave a voice mail with your name, phone number and appointment time and date.

Sincerely,
Dr. Melissa Leedy, Ph.D.
539-777-1129
DrLeedy@legacycounselingservices.com
www.legacycounselngservices.com

PRINT First and Last Name: _____ Date: _____

EPWORTH SLEEPINESS SCALE

Rate the following situations as follows:

Would ***never*** doze	0
Slight chance of dozing	1
Moderate chance of dozing	2
High chance of dozing	3

How likely are you to doze off in each of these situations (write in one number for each situation):

Situation:	**Chance of Dozing:**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour with no break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
	Total: _____

FOR OFFICE USE ONLY:

Johns MW (1991). "A new method for measuring daytime sleepiness: the Epworth sleepiness scale". Sleep **14** (6): 540–5.

0-5 = Super normal
6-10 = Normal
10-15 = Sleepy
15-20 = Very sleepy
If ESS > 10; referral to pulmonary sleep medicine for possible polysomnogram (sleep study) indicated.

INSOMNIA SEVERITY INDEX

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. Problem 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

FOR OFFICE USE ONLY:

Used with permission from Charles M. Morin, Ph.D., Université Laval

0-7 = No clinical significant insomnia
8-14 = Sub threshold insomnia
15-21 = Moderately Severe Clinical Insomnia
22-28 = Severe Clinical Insomnia

STOP Questionnaire

1. **S**noring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? Yes/No

2. **T**ired: Do you often feel tired, fatigued, or sleepy during daytime? Yes/No

3. **O**bserved: Has anyone observed you stop breathing during your sleep? Yes/No

4. Blood **P**ressure: Do you have or are you being treated for high blood pressure? Yes /No

Chung F, Yegneswaran B, Liao P, Chung SA, Vairavanathan S, Islam S, Khajehdehi A, Shapiro CM. STOP questionnaire: a tool to screen patients for obstructive sleep apnea. Anesthesiology. 2008 May; 108(5):812-21.

Scoring: High risk of OSA: answering yes to two or more questions
Low risk of OSA: answering yes to less than two questions

Smith's (1989) Measure of Morningness/Eveningness

Directions: For each item, please ***check one*** response that best describes you.

1. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
   ___a.(5) 5:00-6:30 a.m.
   ___b.(4) 6:30-7:45 a.m.
   ___c.(3) 7:45—9:45 a.m.
   ___d.(2) 9:45-11:00 a.m.
   ___e.(1) 11:00 a.m. – 12:00 noon

2. Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
   ___a.(5) 8:00 - 9:00 p.m.
   ___b.(4) 9:00 - 10:15 p.m.
   ___c.(3) 10:15 p.m.- 12:30 a.m.
   ___d.(2) 12:30 - 1:45 a.m.
   ___e.(1) 1:45 a.m. – 3:00 a.m.

3. Assuming normal circumstances, how easy do you find getting up in the morning?
   ___a.(1) Not at all easy
   ___b.(2) Slightly easy
   ___c.(3) Fairly easy
   ___d.(4) Very easy

4. How alert do you feel after the first half hour after having awakened in the morning?
   ___a.(1) Not at all alert
   ___b.(2) Slightly alert
   ___c.(3) Fairly alert
   ___d.(4) Very alert

5. During the first half hour after having awakened in the morning, how tired do you feel?
   ___a.(1) Very tired
   ___b.(2) Fairly tired
   ___c.(3) Slightly tired
   ___d.(4) Not at all tired

6. You have decided to engage in some physical exercise. A friend suggests that you do this one hour twice a week and the best time for him is 7:00-8:00 am. Bearing in mind nothing else but your "feeling best" rhythm, how do you think you would perform?
   ___a.(4) Would be in good form
   ___b.(3) Would be in reasonable form
   ___c.(2) Would find it difficult
   ___d.(1) Would find it very difficult

6. At what time in the evening do you feel tired and as a result, in need of sleep?
___a.(5) 8:00 -9:00 p.m.
___b.(4) 9:00 - 10:15 p.m.
___c.(3) 10:15 p.m. – 12:30 a.m.
___d.(2) 12:30 - 1:45 a.m.
___e.(1) 1:45 a.m. – 3:00 a.m.

8. You wish to be at your peak performance for a test, which you know is going to be mentally exhausting and lasting for two hours. You are entirely free to plan your day, and considering only your own" feeling best" rhythm, which ONE of the four testing times would you choose?
___a.(4) 8:00 - 10:00 a.m.
___b.(3) 11:00 a.m. - 1:00 p.m.
___c.(2) 3:00 - 5:00 p.m.
___d.(1) 7:00-9:00 p.m.

9. One hears about "morning" and "evening" type people. Which ONE of these types do you consider yourself to be?
___a.(4) Definitely a morning type
___b.(3) More a morning than an evening type
___c.(2) More an evening than a morning type
___d.(1) Definitely an evening type

10. When would you prefer to rise (provided you have a full day's work – 8 hours) if you were totally free to arrange your time?
___a.(4) Before 6:30 a.m.
___b.(3) 6:30 – 7:30 a.m.
___c.(2) 7:30 - 8:30 a.m.
___d.(1) 8:30 a.m. or later

11. If you always had to rise at 6:00 am, what do you think it would be like?
___a.(1) Very difficult and unpleasant
___b.(2) Rather difficult and unpleasant
___c.(3) A little unpleasant but no great problem
___d.(4) Easy and not unpleasant

12. How long a time does it usually take before you "recover your senses" in the morning after rising from a night's sleep?
___a.(4) 0-10 minutes
___b.(3) 11-20 minutes
___c.(2) 21-40 minutes
___d.(1) More than 40 minutes

13. Please indicate to what extent you are a morning or an evening active individual?
___a.(4) Very morning active (morning alert & evening tired)
___b.(3) To some extent, morning active
___c.(2) To some extent, evening active
___d.(1) Very evening active (morning tired & evening alert)

[1]Smith CS, Reilly C, Midkiff K. Evaluation of three circadian rhythm questionnaires with suggestions for an improved measure of morningness. *J Appl Psychol.* Oct 1989;74(5):728-738.
Scoring: Evening Type = 22 and less; Intermediate Type = 23-43; Morning Type = 44 and above.

Restless Legs Syndrome Rating Scale

Restless Leg Syndrome is an uncomfortable sensations in the legs (and sometimes arms or other parts of the body) and an irresistible urge to move the legs to relieve the sensations. The condition causes an uncomfortable, "itchy," "pins and needles," or "creepy crawly" feeling in the legs. The sensations are usually worse at rest, especially when lying or sitting.

Please circle the best answer in the questions below**. In the past week…**

(1) Overall, how would you rate the RLS discomfort in your legs or arms?
_ (4) Very severe
_ (3) Severe
_ (2) Moderate
_ (1) Mild
_ (0) None

(2) Overall, how would you rate the need to move around because of your RLS symptoms?
_ (4) Very severe
_ (3) Severe
_ (2) Moderate
_ (1) Mild
_ (0) None

(3) Overall, how much relief of your RLS arm or leg discomfort did you get from moving around?
_ (4) No relief
_ (3) Mild relief
_ (2) Moderate relief
_ (1) Either complete or almost complete relief
_ (0) No RLS symptoms to be relieved

(4) How severe was your sleep disturbance due to your RLS symptoms?
_ (4) Very severe
_ (3) Severe
_ (2) Moderate
_ (1) Mild
_ (0) None

(5) How severe was your tiredness or sleepiness during the day due to your RLS symptoms?
_ (4) Very severe
_ (3) Severe
_ (2) Moderate
_ (1) Mild
_ (0) None

(5) How severe was your RLS as a whole?
_ (4) Very severe
_ (3) Severe
_ (2) Moderate
_ (1) Mild
_ (0) None

(6) How often did you get RLS symptoms?
_ (4) Very often (6 to 7 days in 1 week)
_ (3) Often (4 to 5 days in 1 week)
_ (2) Sometimes (2 to 3 days in 1 week)
_ (1) Occasionally (1 day in 1 week)
_ (0) Never

(7) When you had RLS symptoms, how severe were they on average?
_ (4) Very severe (8 hours or more per 24 hour)
_ (3) Severe (3 to 8 hours per 24 hour)
_ (2) Moderate (1 to 3 hours per 24 hour)
_ (1) Mild (less than 1 hour per 24 hour)
_ (0) None

(8) Overall, how severe was the impact of your RLS symptoms on your ability to carry out your daily affairs, for example, carrying out a satisfactory family, home, social, school or work
_ (4) Very severe
_ (3) Severe
_ (2) Moderate
_ (1) Mild
_ (0) None

(9) How severe was your mood disturbance due to your RLS symptoms - for example, angry, depressed, sad, anxious or irritable?
_ (4) Very severe
_ (3) Severe
_ (2) Moderate
_ (1) Mild
_ (0) None

FOR OFFICE USE ONLY:
The International Restless Legs Syndrome Study Group (Arthur S. Walters MD – Group Organizer and Correspondent), Towards a better definition of the restless legs syndrome. Mov Disord 10 (1995), pp. 634–642.
Scoring:

Mild (score 1-10); Moderate (score 11-20) ; Severe (score 21-30) ; Very severe (score 31-40)

Beliefs About Sleep

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate (by circling the number) to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, **circle a number that best reflects your personal experience**. Consider the whole scale, rather than only the extremes of the continuum.

1. I need 8 hours of sleep to feel refreshed and function well during the day.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
2. When I do not get proper amount of sleep on a given night, I need to catch up on the next day by napping or on the next night by sleeping longer.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
3. I am concerned that chronic insomnia may have serious consequences for my physical health.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
4. I am worried that I may lose control over my abilities to sleep.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
5. After a poor night's sleep, I know that it will interfere with my daily activities on the next day.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
6. In order to be alert and function well during the day, I am better off taking a sleeping pill rather than having a poor night's sleep.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
8. When I sleep poorly on one night, I know that it will disturb my sleep schedule for the whole week.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
9. Without an adequate night's sleep, I can hardly function the next day.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
10. I can't ever predict whether I will have a good or poor night's sleep.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
11. I have little ability to manage the negative consequences of disturbed sleep.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
12. When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
13. I believe that insomnia is essentially a result of a chemical imbalance.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
14. I feel that insomnia is ruining my ability to enjoy life and prevents me from doing what I want.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
15. Medication is probably the only solution to sleeplessness.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*
16. I avoid or cancel obligations (social, family, occupational) after a poor night's sleep.	*Strongly Disagree*	0	1	2	3	4	5	6	7	8	9	10	*Strongly Agree*

Morin CM; Vallières A; Ivers H. Dysfunctional Beliefs and Attitudes about Sleep (DBAS): Validation of a Brief Version (DBAS-16). SLEEP 2007;30(11):1547-1554. **Scoring:** Compute the average of all completed16 items. A higher score reflects greater dysfunctional beliefs about sleep. Target beliefs expressed in items with scores > 5.

Sleep Diary Name:________________________________

	Sample							
Today's date	4/5/08							
In total, how long did you nap or doze yesterday?	n/a							
1. What time did you get into bed?	10:15 p.m							
2. What time did you try to go to sleep?	11:30 p.m							
3. How long did it take you to fall asleep?	1 hour 15 min.							
4. How many times did you wake up, not counting your final awakening?	3 times							
5. In total, how long did these awakenings last?	1 hour 10 min.							
6a. What time was your final awakening? 6b. Did you wake up earlier than you desired? 6c. If yes, how many minutes earlier?	6:35 a.m. ❒ Yes ☐ No 30 min.							
7. What time did you get out of bed for the day?	7:20 a.m							
8. How would you rate the quality of your sleep?	☐ Very poor ❒ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐Poor ☐ Fair ☐ Good ☐ Very good
9. Comments (if applicable)	I have a cold							

Sleep Diary Instructions

What is a Sleep Diary? A sleep diary is designed to gather information about your daily sleep pattern.

How often and when do I fill out the sleep diary? It is necessary for you to complete your sleep diary every day. Ideally, the sleep diary should be completed within one hour of getting out of bed in the morning.

What should I do if I miss a day? If you forget to fill in the diary or are unable to finish it, leave the diary blank for that day.

What if something unusual affects my sleep or how I feel in the daytime? If your sleep or daytime functioning is affected by some unusual event (such as an illness, or an emergency) you may make brief notes on your diary.

What do the words "bed" and "day" mean on the diary? This diary can be used for people who are awake or asleep at unusual times. In the sleep diary, the word "day" is the time when you choose or are required to be awake. The term "bed" means the place where you usually sleep.

Will answering these questions about my sleep keep me awake? This is not usually a problem. You should not worry about giving exact times, and you should not watch the clock. Just give your best estimate.

Item Instructions

Use the guide below to clarify what is being asked for each item of the Sleep Diary.

Date: Write the date of the morning you are filling out the diary

In total, how long did you nap or doze? Estimate the total amount of time you spent napping or dozing, specifying if you are referring to hours or minutes. For instance, if you napped twice, once for 30 minutes and once for 60 minutes, and dozed for 10 minutes, you would answer "1 hour 40 minutes." If you did not nap or doze, write "N/A" (not applicable). *1. What time did you get into bed?* Write the time that you got into bed. This may not be the time that you began "trying" to fall asleep.

2. What time did you try to go to sleep? Record the time that you began "trying" to fall asleep.

3. How long did it take you to fall asleep? Beginning at the time you wrote in question 2, how long did it take you to fall asleep.

4. How many times did you wake up, not counting your final awakening? How many times did you wake up between the time you first fell asleep and your final awakening?

5. In total, how long did these awakenings last? What was the total time you were awake between the time you first fell asleep and your final awakening. For example, if you woke 3 times for 20 minutes, 35 minutes, and 15 minutes, add them all up (20+35+15= 70 min or 1 hr and 10 min).

6a. What time was your final awakening? Record the last time you woke up in the morning.

6b. Did you wake up earlier than you planned? If you woke up or were awakened earlier than you planned, check yes. If you woke up at your planned time, check no.

6c. If yes, how much earlier? If you answered “yes” to question 6c, write the number of minutes you woke up earlier than you had planned on waking up. For example, if you woke up 15 minutes before the alarm went off, record 15 minutes here.

7. How would you rate the quality of your sleep? “Sleep Quality” is your sense of whether your sleep was good or poor.

8. Comments Feel free to write anything that you would like to say that is relevant to your sleep.