

DREAMS *program*

DIAGNOSE, RECOGNIZE, EVALUATE AND MANAGE SLEEP DISORDERS

OUR PROGRAM IS DESIGNED TO HELP PATIENTS REALIZE THEIR DREAMS AND GET THE BEST REST OF THEIR LIVES.

Approximately 70 million people in the United States suffer from sleep deprivation. About 40 million Americans suffer from a chronic sleep disorder. Children, adolescents and young adults, middle aged adults, and especially the elderly are affected. Surprisingly, the majority of sleep disorders remain undiagnosed and untreated. (National Commission on Sleep Disorders Research)

Left untreated, a sleep disorder can rob a healthy body of its vitality, proper function and regular metabolism. Over time, the continued stress on your heart and vital organs begins to seriously damage your organs. Your body needs the opportunity to restore itself for the next day to be able to efficiently perform your daily routines.

The care providers can properly diagnose a sleep disorder and get you back on track to a healthy and vital life. **How's Your Sleep?** Take this quick diagnostic quiz today. Share the results with your provider to learn what goes on when the lights go out and how to get **"The Best Rest of Your Life.sm"**

- | | | | |
|-----|---|----------------------------|-----------------------------|
| 1. | I FEEL SLEEPY DURING THE DAY, EVEN WHEN I GET A GOOD NIGHT'S SLEEP. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 2. | I GET VERY IRRITABLE WHEN I CAN'T SLEEP. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 3. | I OFTEN WAKE UP AT NIGHT AND HAVE TROUBLE FALLING BACK TO SLEEP. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 4. | IT USUALLY TAKES ME A LONG TIME TO FALL ASLEEP. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 5. | I OFTEN WAKE UP EARLY AND CAN'T FALL BACK ASLEEP. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 6. | I EXPERIENCE AN UNCOMFORTABLE/RESTLESS SENSATION IN MY LEGS AT NIGHT. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 7. | MY LEGS OFTEN MOVE OR JERK DURING THE NIGHT. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 8. | I SOMETIMES WAKE UP GASPING FOR BREATH. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 9. | MY BEDPARTNER SAYS MY SNORING KEEPS HIM/HER FROM SLEEPING. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |
| 10. | I HAVE FALLEN ASLEEP WHILE DRIVING. | <input type="radio"/> TRUE | <input type="radio"/> FALSE |

If you answer true 2 or more times, you may have a treatable sleep condition. Please **complete the information on the back of this form** and share your answers with your physician or care provider.



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PATIENT NAME: _____ DOB: ____/____/____ SEX: M F
ADDRESS: _____ SSN: ____-____-____
CITY: _____ STATE: _____ ZIP CODE: _____
BEST PHONE NUMBER TO REACH YOU DURING THE DAY: (_____) _____-_____
ALTERNATE NUMBER FOR EVENINGS OR WEEKENDS: (_____) _____-_____
E-MAIL ADDRESS: _____@_____

DO YOU EXPERIENCE THE FOLLOWING (OR HAVE BEEN TOLD THAT YOU DO): (CHECK ALL THAT APPLY)

OBSTRUCTIVE SLEEP APNEA

- SNORE LOUDLY
- STOP BREATHING
- TOSS AND TURN AT NIGHT
- SWEAT EXCESSIVELY AT NIGHT
- AWAKEN CHOKING OR GASPING
- AWAKEN SHORT OF BREATH
- TIREDNESS IN THE AFTERNOON
- FALL ASLEEP UNINTENTIONALLY
- AWAKEN WITH HEADACHES
- HAVE HIGH BLOOD PRESSURE
- ARE OVERWEIGHT
- HAD A RECENT WEIGHT GAIN
- LOSING SEX DRIVE

RESTLESS LEGS OR PERIODIC LIMB MOVEMENTS

- EXPERIENCE MUSCLE TENSION IN LEGS EVEN WHEN RELAXED
- HAVE BEEN TOLD THAT I KICK AT NIGHT
- EXPERIENCE ACHING OR CRAWLING SENSATIONS IN MY LEGS
- EXPERIENCE LEG PAIN DURING THE NIGHT
- SOMETIMES FEEL LIKE I CAN'T KEEP MY LEGS STILL
- FEEL SLEEPY DURING THE DAY, EVEN AFTER SLEEPING ALL NIGHT

INSOMNIA OR NARCOLEPSY

- VIVID DREAM-LIKE SEQUENCES WHEN WAKING OR FALLING ASLEEP
- FEEL LIKE YOU GO AROUND IN A DAZE
- HAVE FALLEN ASLEEP WHEN LAUGHING OR CRYING
- EVER FEEL UNABLE TO MOVE WHEN WAKING OR FALLING ASLEEP
- HAVE TROUBLE AT WORK DUE TO SLEEPINESS
- LIE AWAKE FOR MORE THAN ½ HOUR BEFORE FALLING ASLEEP

PLEASE SHARE THIS INFORMATION WITH MY PROVIDER.

FOR PROVIDER STAFF USE:

BASED ON THE SYMPTOMS NOTED ABOVE, I AUTHORIZE THIS PATIENT TO BE EVALUATED AND TREATED FOR SLEEP DISORDERS AT A SLEEP HEALERS FACILITY.

PROVIDER OFFICE: _____

PROVIDER NAME: _____

PROVIDER SIGNATURE: _____ DATE: ____/____/____

SPECIAL INSTRUCTIONS: CONSULT WITH SLEEP SPECIALIST
 OTHER _____

PLEASE INCLUDE PATIENT DEMOGRAPHICS AND/OR INSURANCE INFORMATION.

972.506.7800 | 972.831.8015 fax
www.sleephealers.net

