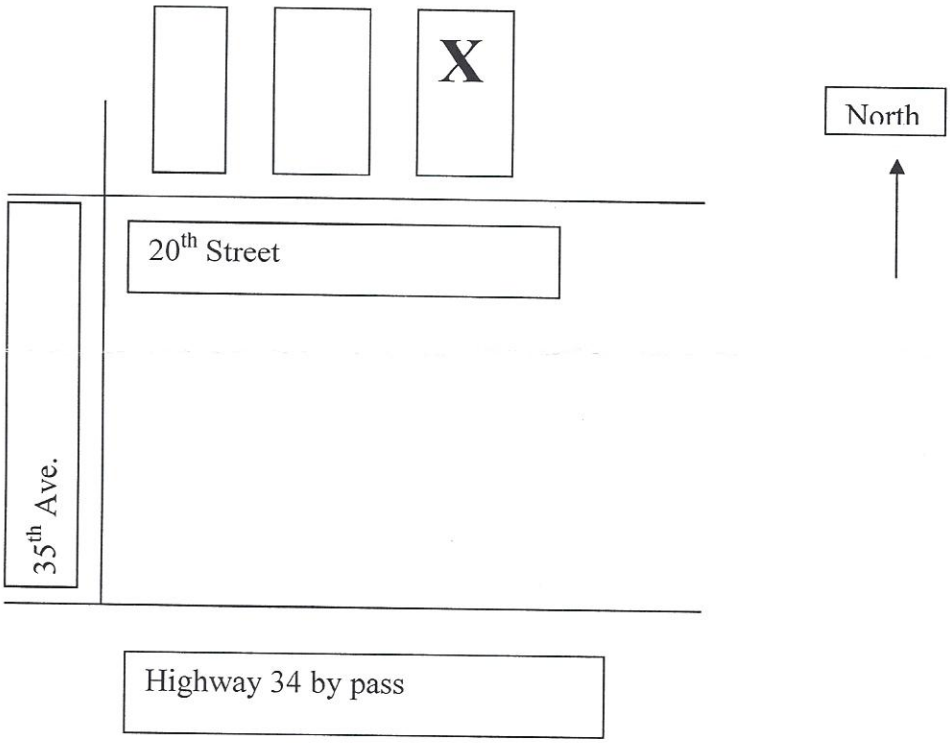
FATIGUE & SLEEP REMEDIES
OF NORTHERN COLORADO

Enhancing quality of life through comprehensive sleep remedies

Fatigue & Sleep Remedies
3211 20th Street Suite B1
Greeley CO 80634
(970) 356-0004



We are the 3rd building from the intersection of 35th Ave. and 20th St. on the north side of the road. Go all the way to the back (north side) of the building and park in front of the only door on the north side. Once in the common hallway we are door on the right. Please call 970.356.0004 with any questions.

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Your physician has ordered a sleep study for you. Please review the following instructions prior to your arrival.

1) Please complete the questionnaire and bring it with you.
2) Please have the Bed-Partner questionnaire completed and bring it with you.
3) Fill out the sleep diary as best you can between now and the time of your study and bring it with you.
4) Please shower or bath before your study.
5) Please use no hairspray, facial lotions or creams, makeup, or fingernail polish.
6) Bring night cloths, slippers, robe, and your favorite pillow if you like. Pajamas or shorts and a T shirt are required.
7) Should you arrive early please call (970) 356-0004 and the technician will meet you at the front door and let you in.
8) Please avoid caffeine and alcohol for 3 hours prior to your appointment.
9) Please bring your insurance card(s) with you so we may copy for billing.

It takes approximately 1 hour to attach electrodes and prepare you for the study. You can expect to spend the night and go home between 5:00 and 6:30 A.M. If a different departure time is needed, please mention it the night of the study and we will accommodate as best we can. A map to our location is included for your convenience. Feel free to contact us at (970) 356-0004 with any questions. Thank you for the opportunity to serve you. We look forward to meeting you at your appointment.

CANCELLATION POLICY

WE REQUIRE AT LEAST 48 HOURS NOTICE OF CANCELLATION. IF YOU FAIL TO GIVE US AT LEAST 48 HOURS NOTICE OR IF YOU FAIL TO SHOW UP FOR YOUR SCHEDULED STUDY, THERE WILL BE A CHARGE OF $100.00 WHICH WILL BE DUE AND PAYABLE BY YOU.

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SLEEP LABORATORY QUESTIONNAIRE

Name: _____ Today's Date_____

Address: _____
_____
_____

Phone Number: _____ Alternate Phone Number: _____

Age: _____Height: _____ Weight: _____ Gender: ☐ M or ☐ F

If Female, are you post-menopausal? ☐ Yes ☐ No

Collar size: _____ inches Smoker? ☐ Yes or ☐ No Drink Alcohol? ☐ Yes ☐ No

Occupation: _____

Do you snore? ☐ Never _____ number of nights a week ☐ Always

If yes, ☐ as loud as breathing ☐ As loud as talking ☐ Heard through walls

Have you been told that you kick your legs frequently during sleep? ☐ Yes ☐ No

Do you frequently have discomfort in your legs and need to walk, rub or move your legs to relieve this discomfort? ☐ Yes ☐ No

Have you suddenly lost your muscle strength and fell to the ground following a fit of anger, a bout of laughter or other emotion? ☐ Yes ☐ No If yes, please explain:
_____
_____
_____

Are you a vivid dreamer? ☐ Yes ☐ No

Do you awaken from sleep feeling paralyzed? ☐ Yes ☐ No

Have you ever been treated for sleep apnea or had a sleep study? ☐ Yes ☐ No

Are you excessively sleepy during the daytime? ☐ Yes ☐ No

How many times during an average weekday do you fall asleep when you don't wish to fall asleep? _____

Approximately how many hours do you sleep each night? _____

Have you ever been in an accident at work or while driving because of sleepiness within this last year? ☐ Yes ☐ No

How often do you actually fall asleep while driving? Check one only:

☐ More than twice per month
☐ Once or twice a month
☐ Less than once per month
☐ Never

Do you frequently complain of depression? ☐ Yes ☐ No

Do you frequently complain of insomnia? ☐ Yes ☐ No

Please list any medications you are currently taking and the dosage:

_____
_____
_____

Do you still have your tonsils and adenoids? ☐ Yes ☐ No

Do you perform any unusual behaviors while you sleep? ☐ Yes ☐ No If yes, please explain: _____
_____
_____

Do you sleep walk frequently? ☐ Yes ☐ No
Do you grind your teeth while sleeping? ☐ Yes ☐ No
Do you awaken from sleep screaming, violent or confused? ☐ Yes ☐ No
Do you often have disturbing nightmares? ☐ Yes ☐ No
Do you have any family members who have been diagnosed with:
☐ Sleep apnea ☐ Narcolepsy ☐ Sleep walking
☐ Any other sleep disorder (please describe): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your day-to-day life in the recent past. Even if you have not done some of these things recently, try to work out how they would have affected you if you had. Use the following scale to choose the most appropriate number for each situation.

0 = would never done
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING 0-3**
Sitting and reading	_____
Watching TV	_____
Sitting in a public place (theatre or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon if time	_____
Sitting and talking with someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
TOTAL	_____

BED-PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Name of person filling out this form: _____

I have observed this person's sleep: ☐ Never ☐ Once or Twice ☐ Often ☐ Every Night

Check any of the following behaviors that you have observed this person doing <u>while asleep</u>.

☐ Light snoring	☐ Loud snoring	☐ Occasional loud snorts
☐ Choking	☐ Pauses in breathing	☐ Twitching or kicking or legs during sleep
☐ Grinding teeth	☐ Sleepwalking	☐ Twitching or jerking of arms during sleep
☐ Bed wetting	☐ Biting tongue	☐ Getting out of bed but not awake
☐ Crying out	☐ Sitting up in bed not awake	
☐ Awakening with pain	☐ Head rocking or banging	
☐ Becoming very rigid and/or shaking	☐ Apparently sleeping even if she/he behaves otherwise	

☐ Other: _____

_____

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ☐ Yes ☐ No If yes, please explain:

_____

_____

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970-356-0004

Patient Name: _____
(Please print)

SLEEP DIARY

Please complete this two-week diary
(if unable to complete two weeks, complete at least one week)

WEEK 1

DAY/DATE							
Time you woke up.							
Time you got out of bed.							
Did you wake up refreshed or tired?							
Note number of naps taken throughout the day.							
Time you went to bed.							
Approximate time you fell asleep.							
Number of times awakened during the night.							
Note any information affecting sleep for the day.							
Note duration of longest nap. (How many minutes?)							

WEEK 2

DAY/DATE							
Time you woke up.							
Time you got out of bed.							
Did you wake up refreshed or tired?							
Note number of naps taken throughout the day.							
Time you went to bed.							
Approximate time you fell asleep.							
Number of times awakened during the night.							
Note any information affecting sleep for the day.							
Note duration of longest nap. (How many minutes?)							