

Participant ID: _____	Date: _____
Evaluator: _____	Appointment: _____

? = insufficient information; 1 = Absent (no); 2 = Subthreshold (uncertain); 3 = Threshold (yes)

What does your sleep look like on a typical week?

Total Sleep Time: _____ Bedtime: _____, Sleep onset latency: _____, Number of Awakenings: _____,
 Wake time after sleep onset: _____, Rise time: _____, Out of bed: _____, Naps: _____?
Notes:

Is your sleep the same on the weekends as during the week? If different:

Total Sleep Time: _____ Bedtime: _____, Sleep onset latency: _____, Number of Awakenings: _____,
 Wake time after sleep onset: _____, Rise time: _____, Out of bed: _____, Naps: _____?
Notes:

If you had no responsibilities, what time would your body tell you to go to sleep and wake up? _____

MINIMAL CRITERIA FOR INSOMNIA

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<p>1. [If not known] Do you ever have difficulty falling asleep, staying asleep, or waking up too early in the morning?</p>	<p>1. Subject reports:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty getting to sleep <input type="checkbox"/> Difficulty staying asleep <input type="checkbox"/> Waking up too early 	<p>? 1 2 3</p>
<p>2. How much do these sleep difficulties interfere with your life?</p> <p>Does your sleep difficulty cause you any problems with your daytime functioning?</p> <p>[If not known, query about each item to the right.]</p>	<p>2. Sleep complaint is accompanied by <u>significant distress</u> OR <u>impairment in daytime functioning</u> as indicated by at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue or low energy <input type="checkbox"/> Daytime sleepiness <input type="checkbox"/> Impaired concentration, attention or memory <input type="checkbox"/> Mood problems or irritability <input type="checkbox"/> Hyperactivity, aggression, or impulsivity <input type="checkbox"/> Work or school problems <input type="checkbox"/> Interpersonal/social problems <input type="checkbox"/> Family problems 	<p>? 1 2 3</p>
<p>3. How many nights a week does this sleep difficulty occur? _____</p>	<p>3. The sleep difficulty occurs at least three nights per week.</p>	<p>? 1 2 3</p>
<p>4. How long have you had this sleep problem? _____</p>	<p>4. The episode lasted at least three months.</p>	<p>? 1 2 3</p>
<p>Minimal Criteria for Insomnia</p>	<p>MET ALL CRITERIA ABOVE.</p>	<p>IF NO TO ANY ITEM, GO TO NEXT SECTION.</p> <p>? 1 2 3</p>

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MINIMAL CRITERIA FOR HYPERSOMNIA

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
1a. [If not known] How long do you typically sleep per day (including night and naps)?	1. Prolonged nocturnal sleep episode or daily sleep amounts (>9 hours/day)	? 1 2 3
1b. Do you suffer from daytime sleepiness? Do you frequently fall asleep unintentionally during the day?	Excessive daytime sleepiness with recurrent lapses into sleep that occur almost daily.	? 1 2 3 IF NO 1a AND 1b, GO TO NEXT SECTION.
3. How long have you had this sleep problem? _____	3. The episode lasted at >3 months.	? 1 2 3
4. How much does this sleepiness interfere with your life?	4. The episodes cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	? 1 2 3 IF NO TO ANY ITEM 3-4, GO TO NEXT SECTION.
Minimal Criteria for Hypersomnia	MET ALL CRITERIA ABOVE.	? 1 2 3

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CIRCADIAN RHYTHM SLEEP DISORDERS

MEETS MINIMAL CRITERIA FOR HYPERSOMNIA OR INSOMNIA.

[Ask the questions below if not known]

Delayed Sleep Phase Type		? 1 2 3
1a. Do you often have difficulty falling asleep before 1am?	1. A persistent or recurrent pattern of delayed sleep onset (e.g., after 1am) <i>and</i> awakening times (e.g., after 10am), with an inability to fall asleep and awaken at a desired or conventionally acceptable earlier times.	
1b. Do you <i>also</i> have difficulty getting up before 10am?		
Advanced Sleep Phase Type		? 1 2 3
2a. Do you often fall asleep before 9 pm?	2. A persistent or recurrent pattern of advanced sleep onset (e.g., before 9pm) and awakening times (e.g., before 4am), with an inability to remain awake and asleep until the desired or conventionally acceptable later sleep and wake times.	
2b. Do you often wake up before 4 am?		
Shift Work Type		? 1 2 3
3. Do you work shift work or the night shift on a regular basis? - Does your shift ever start before 6am? - Does your shift ever end after 9pm?	3. Insomnia during the major sleep period and/or excessive sleepiness (including inadvertent sleep) during the major awake period associated with shift work schedule (i.e., requiring unconventional work hours) of at least one month	
Irregular Sleep-Wake Type		
4. Do you tend to take several naps each 24-hour day rather than sleeping 6 to 8 hours each night?	4. A temporally disorganized sleep and wake pattern, so that sleep and wake periods are variable throughout the 24 hour period	? 1 2 3
Free-Running Type		? 1 2 3
5. Do you seem to only be able to get enough sleep if you go to bed and get up later and later each day?	5. Persistent or recurrent pattern of sleep and wake cycles that are not entrained to the 24 hour environment, with a daily drift (usually to later and later times) of sleep onset wake time	IF NOT TO ALL, GO TO NEXT PAGE
6. Do you think this schedule is the primary reason you are having difficulty sleeping or staying awake?	6. A persistent or recurrent pattern of sleep disruption leading to excessive sleepiness, insomnia, or both that is primarily due to a misalignment between the endogenous circadian rhythm and the sleep-wake schedule required by a person's physical environment or social/professional schedule.	? 1 2 3
Circadian rhythm sleep disorder	(SPECIFY TYPE: _____)	? 1 2 3

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DYSOMNIA NOS: SLEEP DEPRIVATION

MUST MEET MINIMAL CRITERIA FOR HYPERSOMNIA OR INSOMNIA.

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<p>1. [If not known] Do you have enough time each night to get the number of hours of sleep you feel you need?</p>	<p>1. Subject reports inadequate opportunity to sleep. (e.g., <i>Patient has to, or chooses to, go to bed later than needed or get up earlier than needed to get an adequate [e.g., 7 hours] amount of sleep</i>)</p>	<p>? 1 2 3 [Reverse Score]</p>
<p>2. Do you think your sleep problem would go away if you had more/gave yourself more time to sleep?</p>		<p>? 1 2 3</p>
<p>Dysomnia NOS: Sleep deprivation</p>		<p>MET ALL CRITERIA ABOVE</p>
		<p>? 1 2 3</p>

DYSOMNIA NOS: ENVIRONMENTAL FACTORS

MUST MEET MINIMAL CRITERIA FOR HYPERSOMNIA OR INSOMNIA.

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<p>1.[If not known] Are there things out of your control when you are trying to sleep that are causing your difficulty sleeping such as noise, light, or frequent interruptions?</p>	<p>1. The patient's insomnia/hypersomnia complaint is better accounted for by environmental factors that disturb sleep (e.g., <i>barking dog, crying children, train, unsafe neighborhood, snoring spouse</i>)</p>	<p>? 1 2 3</p>
<p>2. Do you think your sleep problem would go away if you could change your sleeping situation (e.g., by going out of town or staying at a hotel)?</p>		<p>? 1 2 3</p>
<p>Dysomnia NOS: Environmental factors</p>		<p>MET ALL CRITERIA ABOVE</p>
		<p>? 1 2 3</p>

OBSTRUCTIVE SLEEP APNEA SYNDROME

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<p>1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?</p>	<p>Symptoms of snoring.</p>	<p>ASK ALL QUESTIONS ? 1 2 3</p>
<p>2. Has anyone observed you stop breathing during your sleep?</p>	<p>Breathing pauses during sleep.</p>	<p>? 1 2 3</p>
<p>3. [If not known] Do you often feel tired, fatigued, or sleepy during daytime?</p>	<p>Daytime sleepiness/fatigue.</p>	<p>? 1 2 3</p>
<p>4. [If not known] Do you have or are you being treated for high blood pressure?</p>	<p>High Blood Pressure</p>	<p>? 1 2 3</p>
<p>Possible Obstructive Sleep Apnea Confirmed with PSG? Yes/No Using CPAP ≥ 4 hrs per night? Yes/No Describe:</p>	<p>YES TO ≥2 CRITERIA ABOVE. PSG date? __/__/__</p>	<p>? 1 2 3</p>

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RESTLESS LEGS SYNDROME

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
1a. Do you often have a very strong urge to move your legs?	1. An urge to move the legs usually accompanied or caused by uncomfortable and unpleasant sensations in the legs.	? 1 2 3
1b. Is this urge accompanied by an unpleasant sensation in your legs such as crawling, tingling, drawing, restlessness, or "electric" sensations?		
2. Does this urge begin/worsen when you are resting or being inactive?	2. The urge or unpleasant sensations begin or worsen during periods of rest or inactivity.	? 1 2 3
3. Are the symptoms worse in the evening/at night?	3. Symptoms are worse in the evening or at night than during the day or are present only at night or in the evening.	? 1 2 3
4. Is the discomfort relieved by movement?	4. Symptoms are partially or totally relieved by movement.	? 1 2 3
5. How much do these symptoms interfere with your life or sleep?	5. These symptoms are accompanied by significant distress or impairment in sleep, social, occupational, educational, academic, behavioral or other important areas of functioning	? 1 2 3
RESTLESS LEGS SYNDROME	MET ALL CRITERIA ABOVE.	? 1 2 3

IF NO TO ANY ITEM, GO TO NEXT SECTION.

PERIODIC LIMB MOVEMENTS

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<u>MEETS MINIMAL CRITERIA FOR HYPERSOMNIA OR INSOMNIA.</u>		
1. Have others told you that your legs or arms twitch repeatedly during your sleep? Please tell me more about that.	1. Bed partner observes repetitive, stereotyped movements during sleep. (Determine that subject is not describing single movements such as hypnic jerks.)	? 1 2 3
Possible periodic limb movement disorder Confirmed with PSG? Yes/No	MET ALL CRITERIA ABOVE. PSG date? __/__/__	? 1 2 3

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DISORDER OF AROUSAL

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
Sleep Walking		
1. Do you get out of bed and walk around [sleep walk] during your sleep?	1. Repeated episodes of rising from bed during sleep and walking about, usually occurring during the first third of the major sleep episode. While sleepwalking, the person has a blank, staring face, and can be awakened only with great difficulty.	? 1 2 3
Sleep Terrors		
2. Do you sometimes awaken at night with intense fear or terror?	2. Recurrent episodes of abrupt awakening from sleep, usually occurring during the first third of the major sleep episode and beginning with a panicky scream. There is intense fear and signs of autonomic arousal, such as tachycardia, rapid breathing, sweating, and dilated pupils.	? 1 2 3
Confusional Arousal		
3. Do you sometimes wake up confused and have difficulty coming to your senses?	3. Recurrent episodes of incomplete awakening from sleep without terror or ambulation, usually occurring during the first third of the major sleep episode. There is a relative lack of autonomic arousal such as tachycardia, rapid breathing, sweating, and dilated pupils during an episode.	? 1 2 3
4. Do you tend to be unresponsive to others during _____ [any affirmative event above]?	4. Relative unresponsiveness to efforts of others to comfort the person during the episode.	? 1 2 3
5. Do you have <i>difficulty</i> remembering these episodes?	5. There is amnesia for the episode.	? 1 2 3
6. Do you have <i>difficulty</i> recalling any dreams during these episodes?	6. No detailed dream is recalled.	? 1 2 3
7. How much do these sleep problems interfere with your life or sleep?	7. The episodes cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	? 1 2 3
DISORDER OF AROUSAL	(SPECIFY TYPE: _____)	IF NO TO ALL, GO TO NEXT PAGE IF NO TO ANY 4-7, GO TO NEXT SECTION. ? 1 2 3

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NIGHTMARE DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<p>1. Do you have recurrent disturbing dreams?</p> <p>_____</p> <p>Do you remember these bad dreams? _____</p> <p>What are the dreams about?</p> <p>_____</p> <p>How often does this happen?</p> <p>_____</p> <p>About what time of night does this happen?</p> <p>_____</p>	<p>1. Repeated awakenings from the major sleep period or naps with <u>detailed recall</u> of extended and extremely <u>dysphoric dreams</u>, usually involving active efforts to avoid threats to survival, security, or physical integrity. The awakenings generally <u>occur during the second half of the sleep period</u>.</p>	<p>? 1 2 3</p>
<p>2. Once you awaken from such dreams, do you quickly become alert and realize that you were having just a bad dream?</p>	<p>2. On awakening from the dysphoric dreams, the person rapidly becomes oriented and alert.</p>	<p>? 1 2 3</p>
<p>3. How much do these nightmares interfere with your life or sleep?</p>	<p>3. The episodes cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p>	<p>? 1 2 3</p>
<p>NIGHTMARE DISORDER</p>		<p>IF NO TO ANY ITEM, GO TO NEXT SECTION.</p> <p>? 1 2 3</p>
MET CRITERIA ABOVE.		

REM SLEEP BEHAVIOR DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<p>1. During sleep have you ever committed violent behaviors that led (or could have led) you to injure yourself or someone else?</p>	<p>1. Repeated episodes of arousal during sleep associated with complex motor behaviors which may be sufficient to result in injury to the individual or bed partner.</p>	<p>? 1 2 3</p>
<p>2. At the time you did this, were you having a dream or nightmare?</p>	<p>2. These behaviors are usually (but not necessarily) associated with dream mentation.</p>	<p>? 1 2 3</p>
<p>3. Did your dream involve a chase, an attack, or a confrontation of some kind?</p>	<p>3. Behaviors are usually (but not necessarily) associated with dreams that involve a chasing, attacking, or confrontational theme.</p>	<p>? 1 2 3</p>
<p>Possible REM Sleep Behavior Disorder</p> <p>Confirmed by Polysomnography? ___/___</p>	<p>MET ALL CRITERIA ABOVE.</p>	<p>? 1 2 3</p>
<p>IF NO TO ANY ITEM, TO NEXT SECTION.</p>		

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NARCOLEPSY

MUST MEET MINIMAL CRITERIA FOR HYPERSOMNIA

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>
<p>1. Do you ever experience sudden muscle weakness or paralysis when you become angry, amused, or emotionally excited?</p> <p>Does this weakness affect both sides of your body?</p> <p>How long do these episodes typically last? _____</p> <p>How often does this occur?</p> <p>_____</p>	<p>1. Cataplexy defined as brief (a few seconds to <u>2 minutes</u>) episodes of sudden <u>bilateral</u> loss of muscle tone with maintained consciousness, most often in association with laughter or joking. These episodes must occur <u>at least a few times per month</u> providing the patient is untreated for these symptoms.</p>	<p>? 1 2 3</p>
<p>Possible Narcolepsy</p> <p>Confirmed by Polysomnography? ___/___</p>	<p>MET ALL CRITERIA ABOVE.</p>	<p>? 1 2 3</p>

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Structured Clinical Interview for DSM-5 Sleep Disorders Module (SCISD) Summary Page

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Module	Specify:		1	2	3
Minimal criteria for insomnia					
1. Difficulty falling asleep, staying asleep, or waking up too early in the morning	<input type="checkbox"/> Difficulty Falling asleep	<input type="checkbox"/> Difficulty Staying asleep	<input type="checkbox"/> Difficulty Waking up too early		
2. Interference with daytime functioning	<input type="checkbox"/> Fatigue or low energy <input type="checkbox"/> Daytime Sleepiness <input type="checkbox"/> Impaired concentration, attention or memory	<input type="checkbox"/> Mood problems or Irritability <input type="checkbox"/> Hyperactivity, aggression or impulsivity <input type="checkbox"/> Work/school problems	<input type="checkbox"/> Interpersonal/social problems <input type="checkbox"/> Family problems		
3. Nights per week	3 or more nights per week (Specify: _____)				
4. Duration	3 months or more (Specify: _____)				
Hypersomnia					1 2 3
Circadian rhythm sleep d/o	Describe:				1 2 3
	<input type="checkbox"/> Delayed Sleep Phase Type <input type="checkbox"/> Advanced Sleep Phase Type <input type="checkbox"/> Shift Work Type	<input type="checkbox"/> Irregular Sleep-Wake Type <input type="checkbox"/> Free Running Type			
Dysomnia NOS: Sleep Deprivation	Describe:				1 2 3
Dysomnia NOS: Environmental	Describe:				1 2 3
Obstructive Sleep Apnea					1 2 3
	Objectively Confirmed with PSG?	PSG Date:			Yes/No
	Currently using CPAP ≥ 4 hrs per night?	Describe:			Yes/No
Restless Legs Syndrome					1 2 3
Periodic Limb Movement Disorder					1 2 3
	Objectively Confirmed with PSG?	Dx since:			Yes/No
Disorder of Arousal	Describe:				1 2 3
	<input type="checkbox"/> Sleep Walking <input type="checkbox"/> Sleep Terrors <input type="checkbox"/> Confusional Arousal				
Nightmare Disorder	Describe (including frequency)				1 2 3
REM Sleep Behavior Disorder	Describe:				1 2 3
	Objectively Confirmed with PSG?	Dx since:			Yes/No
Narcolepsy					1 2 3

- Is the diagnosis co-morbid with other mental health or medical diagnosis? Yes/No
 If so, which? _____

- Did the mental health/medical diagnosis come before or after the sleep problems/insomnia? _____

- Which diagnosis troubles you the most or dominates the others? _____

- Just before the above sleep problems began, did you start using a medication or other substance? Yes/No
 If Yes, describe for each disorder: _____

Completed By: _____

Date Completed: ____/____/____
 MM DD YYYY

Entered By: _____

Date Entered: ____/____/____
 MM DD YYYY