Zentake Testing Account

Epworth Sleepiness Scale

First Name | Last Name | DOB

In your current, usual way of life, how likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired: Even if you have not done some of these things recently, try to work out how they would affect you. It is important that you answer each question as best you can.

Using the following scale, choose the most appropriate number for each situation:

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

How likely are you to doze off or fall asleep in the following situations?

	Never	Slight 1	Moderate 2	High 3
Sitting and reading	○	○	○	○
Watching television	○	○	○	○
Sitting inactive in a public place (e.g. theater or meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Score

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5.

Zentake Testing Account

Fatigue Severity Scale (FSS)

First Name	Last Name	DOB	Date

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you answer for every question.

During the past week, I have found that:

	Disagree 1	- 2	- 3	- 4	- 5	- 6	Agree 7
1. My motivation is lower when I am fatigued.	◯	◯	◯	◯	◯	◯	◯
2. Exercise brings on my fatigue.	◯	◯	◯	◯	◯	◯	◯
3. I am easily fatigued.	◯	◯	◯	◯	◯	◯	◯
4. Fatigue interferes with my physical functioning.	◯	◯	◯	◯	◯	◯	◯
5. Fatigue causes frequent problems for me.	◯	◯	◯	◯	◯	◯	◯
6. My fatigue prevents sustained physical functioning.	◯	◯	◯	◯	◯	◯	◯
7. Fatigue interferes with carrying out certain duties and responsibilities.	◯	◯	◯	◯	◯	◯	◯
8. Fatigue is among my three most disabling symptoms.	◯	◯	◯	◯	◯	◯	◯
9. Fatigue interferes with my work, family, or social life.	◯	◯	◯	◯	◯	◯	◯

Total Score:

Zentake Testing Account

PHQ - 9

First Name | Last Name | DOB

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Total Score

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Zentake Testing Account

Sleep Diary

Please fill out both sections each day

Name

DOB

Start Date

End Date

ANSWER IN THE MORNING AFTER WAKING FOR THE DAY

Day 1

At what time did you first goto bed last night?

Approximately, how long did it take to fall asleep?

About how many times, if any, did you awaken during the night?

Overall, about how many hours did you sleep?

At what time did you awaken (for the last time)this morning?

In general, how did you feel when you woke up?

Day 2

At what time did you first goto bed last night?

Approximately, how long did it take to fall asleep?

About how many times, if any, did you awaken during the night?

Overall, about how many hours did you sleep?

At what time did you awaken (for the last time)this morning?

In general, how did you feel when you woke up?

Day 3

At what time did you first goto bed last night?

Approximately, how long did it take to fall asleep?

About how many times, if any, did you awaken during the night?

Overall, about how many hours did you sleep?

At what time did you awaken (for the last time)this morning?

In general, how did you feel when you woke up?

Day 4

At what time did you first goto bed last night?

Approximately, how long did it take to fall asleep?

About how many times, if any, did you awaken during the night?

Overall, about how many hours did you sleep?

At what time did you awaken (for the last time)this morning?

In general, how did you feel when you woke up?

Day 5

At what time did you first goto bed last night?	Approximately, how long did it take to fall asleep?	About how many times, if any, did you awaken during the night?	Overall, about how many hours did you sleep?	At what time did you awaken (for the last time)this morning?	In general, how did you feel when you woke up?

Day 6

At what time did you first goto bed last night?	Approximately, how long did it take to fall asleep?	About how many times, if any, did you awaken during the night?	Overall, about how many hours did you sleep?	At what time did you awaken (for the last time)this morning?	In general, how did you feel when you woke up?

Day 7

At what time did you first goto bed last night?	Approximately, how long did it take to fall asleep?	About how many times, if any, did you awaken during the night?	Overall, about how many hours did you sleep?	At what time did you awaken (for the last time)this morning?	In general, how did you feel when you woke up?

ANSWER AT BEDTIME JUST BEFORE YOU GO TO SLEEP

Day 1

How much time, if any, did you spend napping during the day?

Did you consume any of these substances during the day?

- [ ] Caffeine (within 6 hours of bedtime)
- [ ] Alcohol (within 1 hour of bedtime)
- [ ] Medication (type)

On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?

Day 2

How much time, if any, did you spend napping during the day?

Did you consume any of these substances during the day?

- [ ] Caffeine (within 6 hours of bedtime)
- [ ] Alcohol (within 1 hour of bedtime)
- [ ] Medication (type)

On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?

Day 3

How much time, if any, did you spend napping during the day?

Did you consume any of these substances during the day?

- [ ] Caffeine (within 6 hours of bedtime)
- [ ] Alcohol (within 1 hour of bedtime)
- [ ] Medication (type)

On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?

Day 4

How much time, if any, did you spend napping during the day?

Did you consume any of these substances during the day?

- [ ] Caffeine (within 6 hours of bedtime)
- [ ] Alcohol (within 1 hour of bedtime)
- [ ] Medication (type)

On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?

Day 5

How much time, if any, did you spend napping during the day?

Did you consume any of these substances during the day?

- [ ] Caffeine (within 6 hours of bedtime)
- [ ] Alcohol (within 1 hour of bedtime)
- [ ] Medication (type)

On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?

Day 6

How much time, if any, did you spend napping during the day?

Did you consume any of these substances during the day?

- [ ] Caffeine (within 6 hours of bedtime)
- [ ] Alcohol (within 1 hour of bedtime)
- [ ] Medication (type)

On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?

Day 7

How much time, if any, did you spend napping during the day?

Did you consume any of these substances during the day?

- [ ] Caffeine (within 6 hours of bedtime)
- [ ] Alcohol (within 1 hour of bedtime)
- [ ] Medication (type)

On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?

Zentake Testing Account

STOP-BANG Sleep Apnea Questionnaire

Patient's Last Name	Patient's First Name	Date of Birth

STOP

	Yes 1	No
Snoring: Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
Tired: Do you often feel TIRED, fatigued, or sleepy during daytime?	○	○
Observed: Has anyone OBSERVED you stop breathing during your sleep?	○	○
Pressure: Do you have or are you being treated for high blood PRESSURE?	○	○

BANG

	Yes 1	No
BMI: Is your BMI more than 35 kg/m2?	○	○
AGE: Are you over 50 years old?	○	○
NECK: Is your neck circumference greater than 16 inches?	○	○
GENDER: Are you male?	○	○

Score

Sleep Evaluation Questionnaire - Child

Child's Name

Racial/ethnic background

- ◯ White/Caucasian
- ◯ Native American
- ◯ Black/African American
- ◯ Latino/Hispanic
- ◯ Asian
- ◯ Multiracial

What are your major concerns about your child's sleep?

What things have you tried to help your child's problem?

FAMILY INFORMATION

MOTHER

Age

Marital Status

Education

Work

- ◯ Full-time
- ◯ Part time
- ◯ Unemployed

Occupation

FATHER

Age

Marital Status

Education

Work

- ◯ Full-time
- ◯ Part time
- ◯ Unemployed

Occupation

FAMILY SLEEP HISTORY

Does mother, father, or sibling haveany of the following sleep disorders?

	Mother	Father	Sibling
Insomnia	☐	☐	☐
Snoring	☐	☐	☐
Sleep Apnea	☐	☐	☐

Restless Legs Syndrome	☐	☐	☐
Periodic Limb Movement Disorder	☐	☐	☐
Sleep walking/Sleep terrors	☐	☐	☐
Sleep Talking	☐	☐	☐

HEALTH HABITS

Does child drink caffeinated beverages?

◯ Yes ◯ No

Amount per day

Wet the bed?

◯ Yes ◯ No

How often?

CURRENT MEDICAL HISTORY

Please list any medication your child currently takes:

	MEDICINE	DOSE	HOW OFTEN?
1			

LONG-TERM MEDICAL PROBLEMS

If your child has long-term medical problems, please list the three you think are most important.

	Medical Problems
1	
2	
3	

SURGERIES / HOSPITALIZATIONS

Has your child had their tonsils removed?

◯ Yes ◯ No

Age

Has child had their adenoids removed?

◯ Yes ◯ No

Age

Has child had ear tubes?

◯ Yes ◯ No

Age

PREGNANCY / DELIVERY

Pregnancy

◯ Normal ◯ Difficult

Delivery

◯ Term ◯ Pre-term
◯ Post-term

Child's birth weight:

Only child?

◯ Yes ◯ No

If no, choose birth order

◯ 1st ◯ 2nd ◯ 3rd ◯ 4th ◯ 5th ◯ 6th

SCHOOL PERFORMANCE

Child's grade in school:

Has your child ever repeated a grade?

◯ Yes ◯ No

Is your child enrolled in any special education class?

◯ Yes ◯ No

How many school days has child missed so far this year?

How many school days did child miss last year?

How many school days was child late for school this year?

How many school days was child late last year?

Child's grades this year

◯ Excellent ◯ Good ◯ Average ◯ Poor
◯ Failing

DOES YOUR CHILD

	Yes	No
Watch TV in bed?	◯	◯
Read in bed?	◯	◯
Eat in bed?	◯	◯
Use a phone, tablet, or computer in bed?	◯	◯
Worry in bed?	◯	◯

SLEEP HISTORY - WEEKDAY SLEEP SCHEDULE

How much time does child sleep in 24 hours on weekdays? (combine day and night)

Child's usual bedtime during weekdays:

Child's usual wake time in morning:

WEEKEND / VACATION SLEEP SCHEDULE

Amount of time child sleeps in 24 hours on weekends and vacations? (combine day and night)

Child's usual bedtime on weekend/vacation nights:

Child's usual wake time on weekend/vacation mornings:

NAP SCHEDULE

Number of days each week child takes a nap:

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If child naps, time of usual nap:

Nap 1

Nap 2

GENERAL SLEEP

Does child have a regular bedtime routine?

- ○ Yes
- ○ No

Does child have own bed?

- ○ Yes
- ○ No

Does child have own bedroom?

- ○ Yes
- ○ No

Is a parent present when child falls asleep?

- ○ Yes
- ○ No

Child usually falls asleep in

- ☐ own room in own bed (alone)
- ☐ parent's room in own bed
- ☐ parent's room in parent's bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed

Child sleeps most of the night in

- ☐ own room in own bed (alone)
- ☐ parent's room in own bed
- ☐ parent's room in parent's bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed

Child usually wakes in the morning in

- ☐ own room in own bed (alone)
- ☐ parent's room in own bed
- ☐ parent's room in parent's bed
- ☐ sibling's room in own bed
- ☐ sibling's room in sibling's bed

Child is usually put to bed by:

- ☐ Mother
- ☐ Father
- ☐ Both parents
- ☐ Self
- ☐ Other

Amount of time child spends in own bedroom before going to sleep:

Does child often awaken during the night?

- ○ Yes
- ○ No

If yes, what is the typical number of times your child awakens?

After nighttime awakening, does child has difficulty falling back to sleep?

◯ Yes ◯ No

If yes, do you think this is a problem?

◯ Yes ◯ No

Is child difficult to awaken in the morning?

◯ Yes ◯ No

If yes, do you think this is a problem?

◯ Yes ◯ No

Child is a poor sleeper?

◯ Yes ◯ No

If yes, do you think this is a problem?

◯ Yes ◯ No

Is child excessively sleepy?

◯ Yes ◯ No

Does child fall asleep in school?

◯ Yes ◯ No

Does child nap after school?

◯ Yes ◯ No

CURRENT SLEEP SYMPTOMS

Does your child snore?

◯ Never ◯ Occasionally ◯ Frequently ◯ Always

Does position affect snoring?

◯ Yes ◯ No

If yes, what position is worse?

◯ Back ◯ Stomach ◯ Right side ◯ Left side

Does your child wake up coughing?

◯ Daily ◯ Weekly ◯ 1-3 times per month ◯ Never

Does your child stop breathing during sleep?

◯ Daily ◯ Weekly ◯ 1-3 times per month ◯ Never

Does your child wake up choking?

◯ Daily ◯ Weekly ◯ 1-3 times per month ◯ Never

Does your child wake with a stomach acid taste in their mouth?

◯ Daily ◯ Weekly ◯ 1-3 times per month ◯ Never

Does your child wake up with dry mouth/sore throat/headache?

◯ Daily ◯ Weekly ◯ 1-3 times per month ◯ Never

Does your child wake up confused in the morning?

◯ Daily ◯ Weekly ◯ 1-3 times per month ◯ Never

Has your child experienced excessive weight gain over the past months or years?

◯ Yes ◯ No

Have you attempted to place your child on a diet to lose weight?

◯ Yes ◯ No

If yes, how much weight?

Does your child dream during naps or sleep?

◯ Yes ◯ No

Has your child ever felt sudden muscle weakness when laughing, angry, or surprised?

◯ Yes ◯ No

If yes, describe.

Has your child ever been unable to move their body when falling asleep or waking?

◯ Yes ◯ No

If yes, describe.

Has your child ever reported any visual hallucinations or exceptionally vivid dreams just as falling asleep or awakening?

◯ Yes ◯ No

If yes, describe.

PARASOMNIAS

Does your child have episodes of flailing arms/kicking legs/talking/screaming during sleep?

◯ Nightly ◯ Weekly ◯ 1-3 times per month ◯ Never

Are they able to recall a dream preceding these episodes?

◯ Nightly ◯ Weekly ◯ 1-3 times per month ◯ Never

Are they able to remember an episode in the morning?

◯ Yes ◯ No

If yes, describe

Does your child walk in their sleep?

◯ Yes ◯ No

If yes, how often?

In a typical week, mark the frequency of each of these:

	Always	Often	Sometimes	Seldom	Never	Don't Know
Restless Leg	◯	◯	◯	◯	◯	◯
Sweating when sleeping	◯	◯	◯	◯	◯	◯
Poor appetite	◯	◯	◯	◯	◯	◯
Nightmares	◯	◯	◯	◯	◯	◯
Kicks legs in sleep	◯	◯	◯	◯	◯	◯
Gets out of bed at night	◯	◯	◯	◯	◯	◯
Trouble staying in bed	◯	◯	◯	◯	◯	◯
Resists going to bed at night	◯	◯	◯	◯	◯	◯
Grinds teeth	◯	◯	◯	◯	◯	◯
Uncomfortable, creepy crawly feeling in legs	◯	◯	◯	◯	◯	◯

MEDICAL AND PSYCHIATRIC HISTORY

Frequent nasal congestion

◯ Yes ◯ No

Age of Diagnosis ____________________

Trouble Breathing through nose

◯ Yes ◯ No

Age of Diagnosis ____________________

Sinus Problems

◯ Yes ◯ No

Age of Diagnosis ____________________

Chronic bronchitis or cough

◯ Yes ◯ No

Age of Diagnosis ____________________

Allergies

◯ Yes ◯ No

Age of Diagnosis ____________________

Asthma

◯ Yes ◯ No

Age of Diagnosis ____________________

Frequent colds or flu

◯ Yes ◯ No

Age of Diagnosis ____________________

Frequent ear infections

◯ Yes ◯ No

Age of Diagnosis

Frequent strep throat infection

◯ Yes ◯ No

Age of Diagnosis

Difficulty swallowing

◯ Yes ◯ No

Age of Diagnosis

Acid reflux (gastroesophageal reflux)

◯ Yes ◯ No

Age of Diagnosis

Poor or delayed growth

◯ Yes ◯ No

Age of Diagnosis

Excessive weight

◯ Yes ◯ No

Age of Diagnosis

Hearing problems

◯ Yes ◯ No

Age of Diagnosis

Speech Problems

◯ Yes ◯ No

Age of Diagnosis

Vision problems

◯ Yes ◯ No

Age of Diagnosis

Seizures/Epilepsy

◯ Yes ◯ No

Age of Diagnosis

Morning headaches

◯ Yes ◯ No

Age of Diagnosis

Cerebral palsy

◯ Yes ◯ No

Age of Diagnosis

Heart disease

◯ Yes ◯ No

Age of Diagnosis

____

High Blood Pressure

◯ Yes ◯ No

Age of Diagnosis

____

Sickle cell disease

◯ Yes ◯ No

Age of Diagnosis

____

Genetic Disease

◯ Yes ◯ No

Age of Diagnosis

____

Chromosome problem (e.g. Down's)

◯ Yes ◯ No

Age of Diagnosis

____

Autism

◯ Yes ◯ No

Age of Diagnosis

____

Developmental delay

◯ Yes ◯ No

Age of Diagnosis

____

Hyperactivity/ADHD

◯ Yes ◯ No

Age of Diagnosis

____

Obsessive Compulsive Disorder

◯ Yes ◯ No

Age of Diagnosis

____

Depression

◯ Yes ◯ No

Age of Diagnosis

____

Suicide attempt

◯ Yes ◯ No

Age of Diagnosis

____

Learning disability

◯ Yes ◯ No

Age of Diagnosis

____

Drug use/abuse

◯ Yes ◯ No

Age of Diagnosis

Behavioral disorder

◯ Yes ◯ No

Age of Diagnosis

Psychiatric admission

◯ Yes ◯ No

Age of Diagnosis

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.

	Problem Diagnosed	Physician who Diagnosed	When
1			