Client Intake Form: Sleep Apnea Screening Questionnaire

Client Information

- **Name:**
- **Date:**
- **Age:**
- **Gender:**
- **Weight:**
- **Height:**
- **Occupation:**

Symptom Assessment

1. Do you snore loudly, often described as disruptive by others?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently
2. Have you been told that you stop breathing or gasp for air during sleep?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently
3. Do you wake up feeling unrefreshed, even after a full night's sleep?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently

4. Do you often experience excessive daytime sleepiness or feel the need to nap?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently
5. Do you have trouble concentrating, memory issues, or feel mentally foggy during the day?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently
6. Do you wake up with a dry mouth, sore throat, or headache?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently
7. Do you experience frequent nighttime urination (more than once per night)?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently

Lifestyle & Risk Factors

8. Do you drink alcohol in the evening or close to bedtime?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently

9. Do you use sedatives or sleep medications?
    - ( ) Never
    - ( ) Occasionally
    - ( ) Frequently
10. Do you sleep on your back most of the time?

- ( ) Never
- ( ) Occasionally
- ( ) Frequently

11. Do you regularly consume caffeine late in the day?

- ( ) Never
- ( ) Occasionally
- ( ) Frequently

Medical History

12. Do you have high blood pressure or a history of cardiovascular issues?

- ( ) Yes
- ( ) No

13. Have you been diagnosed with Type 2 Diabetes or insulin resistance?

- ( ) Yes
- ( ) No

14. Do you have a family history of sleep apnea or other sleep disorders?

- ( ) Yes
- ( ) No

15. Have you been diagnosed with nasal congestion, allergies, or sinus issues?

- ( ) Yes
- ( ) No

Sleep Patterns

16. How many hours of sleep do you typically get each night?
- ( ) Less than 5 hours
- ( ) 5-6 hours
- ( ) 7-8 hours
- ( ) More than 8 hours
17. Do you have trouble falling asleep or staying asleep?
- ( ) Never
- ( ) Occasionally
- ( ) Frequently
18. Have you noticed a pattern of waking up at specific times during the night?
- ( ) Never
- ( ) Occasionally
- ( ) Frequently

Screening Scores and Follow-Up

- For scoring, assign points to responses based on severity/frequency:
  - **0** = **Never, 1** = **Occasionally, 2** = **Frequently**
- A higher total score may indicate a greater likelihood of sleep apnea. Clients with significant risk factors or symptoms should be referred for further evaluation, such as a sleep study or consultation with a specialist.

Additional Notes

Please share any additional information you feel is important regarding your emotional health, lifestyle, or recent experiences: