Auckland Sleep Questionnaire

Demographics
Q1

a. **First name** _____ **Family name** _____

Please tick appropriate box:

b. Gender: ☐ Male ☐ Female

c. Age in years: _____

d. What ethnic group do you belong to? ***(Tick appropriate box-you can tick more than one)***

- ☐ NZ European
- ☐ Maori
- ☐ Cook Island Maori
- ☐ Samoan
- ☐ Tongan
- ☐ Asian If ***yes***, which country: _____
- ☐ Indian
- ☐ Other: _____

e. What is your present marital status?

- ☐ Single
- ☐ Married
- ☐ Defacto
- ☐ Civil Union
- ☐ Divorced
- ☐ Widow/widower

f. What is your home phone number? _____
g. What is your mobile number? _____
h. What is your work number? _____
i. Which is the best time to contact you? _____
j. What is your email address? _____
k. Home address? _____
_____

Current sleep
Q2

Please answer the following:

a. Do you have problems getting to sleep, staying asleep, poor quality sleep, or waking early such that it affects your functioning the next day – this includes feeling excessively sleepy the next day?

☐ No ☐ Yes

b. Does this occur 3 or more times per week?

☐ No ☐ Yes

c. Has it been like this for more than one month?

☐ No ☐ Yes

d. How long have you had this problem? _____

e. If ***yes,*** was there some event that caused this? (Please describe.)
Were there specific reasons for your poor sleep? i.e. baby crying, sick family member, partying too late, work/school requirements? _____

f. Do you need medication to help your sleep, mood or stress?
Please tick one:

☐ Not during the past month
☐ Less than once a week
☐ Once or twice a week
☐ Three or more times a week

Office use only:
PSQI 7

g. If ***yes,*** what is the name of this medicine(s) _____

h. During the past month, how would you rate your sleep quality overall?
Please tick one:

☐ Very good
☐ Fairly good
☐ Fairly bad
☐ Very bad

Sleep hygiene questions
Q3

a. Do you find your bed/bedroom uncomfortable or annoying?

☐ No ☐ Yes

b. If ***yes***, why is this? _____

c. Do you routinely use alcohol, nicotine (cigarettes) or caffeine (coffee, cola, tea, chocolate, energy drinks) in the evenings?

☐ No ☐ Yes

d. If ***yes***, which one(s)? _____

e. Do you engage in mentally stimulating, moderate to strenuous exercise, or emotionally upsetting activities within a couple of hours of bedtime, more than three times a week?

☐ No ☐ Yes

f. Do you frequently use the bed for activities other than sleep or intimacy? (e.g., television watching, reading, studying, snacking, thinking, planning)

☐ No ☐ Yes

g. Do you frequently nap during the day or have highly irregular and variable bedtimes or rising times?

☐ No ☐ Yes

h. How many days per week do you have naps? _____

i. Do you have any health problems that affect your ability to sleep well on most nights (such as pain, breathing difficulty or stomach acid reflux or night cough or going to the toilet 3 or more times at night)?

☐ No ☐ Yes

j. If ***yes,*** which one(s) and how long have you had this problem(s) _____

Mood (PHQ 9)

Q4

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle the number that applies to you including <u>not at all</u> where that is the case

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things?	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you have had any thoughts about harming yourself please discuss this with your doctor

Stress (GAD 7)
Q5

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

Please circle the number that applies to you including <u>not at all</u> where that is the case.

		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Having trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

Q6

a. Do you have recurrent severe nightmares that wake you up?
☐ No ☐ Yes

b. If ***yes***, how often does this happen? _____

Q7

a. Do you wake up in the middle of the night having an anxiety or panic attack? (palpitations, pounding heart, difficulty breathing, shaking, feeling faint?)
☐ No ☐ Yes

b. If ***yes***, how often does this happen? _____

Alcohol
Q8

a. Do you drink alcohol?

☐ No If ***no,*** go to Q9.

☐ Yes If ***yes,*** choose one of the answers below:

Questions	Scoring system					Your score
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Hot flushes
Q9

Women only *(men go to Q10)*

a. Are you postmenopausal?

☐ No ☐ Yes

b. If ***yes***, do you experience hot flushes?

☐ No ☐ Yes

c. If ***yes***, how many times per night do you awaken due to hot flushes? _____

d. If ***yes***, do these significantly affect your sleep?

☐ No ☐ Yes

e. If ***yes***, how many nights per week do you experience insomnia due to the hot flushes?

_____

Sleep apnoea
Q10

Both men and women continue from here

a. Do you experience excessive sleepiness during the day? (e.g. falling asleep in waiting rooms, lectures or when a passenger in a car?)

☐ No ☐ Yes

b. Do you experience frequent episodes of breathing pauses (or gasping for air) during sleep. Or has someone told you that you stop breathing or make choking noises while you are asleep?

☐ No ☐ Yes

c. Do you snore very loudly? ☐ No ☐ Yes

d. Do you get morning headaches? ☐ No ☐ Yes

e. Do you have a dry mouth upon awakening? ☐ No ☐ Yes

Parasomnias/circadian
Q11

a. At night or later in the day, do you get unpleasant sensations in your legs (aches, pains, creeping sensations or an irresistible urge to move your legs) which affects your sleep?

☐ No ☐ Yes

b. If ***yes***, does the urge to move or the unpleasant sensations begin or worsen during periods of rest or inactivity such as lying or sitting?

☐ No ☐ Yes

c. If ***yes***, are these sensations relieved by movement, rubbing or walking?

☐ No ☐ Yes

d. If you answered ***yes*** to either **a,** or **b**, are these sensations severe enough to affect your sleep?

☐ No ☐ Yes

e. How many nights per week does this happen?

f. On a scale of 1 to 10 with 10 being very severe how do you rate these sensations?

Q12

a. Do you grind your teeth or clench your teeth when asleep? ☐ No ☐ Yes
If ***no,*** go to ***Q13.***

If ***yes,*** do you have:

b. Abnormal wear of your teeth? ☐ No ☐ Yes

c. Sounds associated with teeth grinding? ☐ No ☐ Yes

d. Jaw muscle discomfort? ☐ No ☐ Yes

e. If you answered ***yes*** to either ***a***, or ***b***, or ***c***, or ***d***, is your teeth grinding severe enough to affect your sleep?

☐ No ☐ Yes

Q13

a. Are you a shift worker?

☐ No If ***no,*** go to ***Q7*****.**

☐ Yes If ***yes,*** choose one of the answers below:

b. Do you work the same shift? e.g. nights ☐ No ☐ Yes

c. Do you do rotating shifts? ☐ No ☐ Yes

d. A combination of both? ☐ No ☐ Yes

e. If ***yes,*** do you have problems with your sleep that may be caused by being a shift worker?
☐ No ☐ Yes ☐ Partially

Q14

a. Do you find yourself still quite awake and alert around or after midnight?
☐ No ☐ Yes

If no go to 14g.

b. Given the chance, would you rather wake up late morning or midday and feel refreshed?
☐ No ☐ Yes

c. In the weekends or on holiday (when you can sleep when you want) do you go to sleep late (after 1am) and wake up in the late morning or afternoon and feel like you have had a good night's sleep?
☐ No ☐ Yes

d. Do you have difficulty staying awake in the early evening (6-9pm)?
☐ No ☐ Yes

e. Do you typically wake between 2-5am in the morning? ☐ No ☐ Yes

f. If you can follow your own sleep schedule (e.g. on holidays or at weekends), do you go to bed before 9pm and wake before 5am and feel like you have had a good night's sleep?
☐ No ☐ Yes

For the questions below, your answers should indicate the most accurate reply for the majority of days and nights in the past month:

g. During the past month, when have you usually gone to bed at night?
Usual bed time is _____

h. During the past month, how long (in minutes) has it usually taken you to fall asleep each night after you have turned out the light? NUMBER OF MINUTES _____

i. During the past month, when have you usually woken up in the morning?_____

j. During the past month, how many hours of actual sleep did you get at night? (This may be different from the hours you spend in bed) HOURS OF SLEEP PER NIGHT _____

Q15

a. Do you sleep walk? ☐ No ☐ Yes
If ***no,*** go to ***Q16***

If ***yes,*** during these episodes:
b. Are you difficult to wake? ☐ No ☐ Yes

c. Are you confused if you are awoken during an episode? ☐ No ☐ Yes

d. Do you have no memory or partial memory only of the episode? ☐ No ☐ Yes

e. Do these episodes affect your functioning the following day? ☐ No ☐ Yes

Q16

a. Do you carry out routine behaviours at inappropriate times (e.g. eating or talking)?

☐ No ☐ Yes

b. Do you have unusual or difficult to explain behaviours at night?

☐ No ☐ Yes

c. Do you have dangerous or potentially dangerous behaviours?

☐ No ☐ Yes

d. Do you have any other sleep disorders, medical disorders or substance use that may explain the above behaviours?

☐ No ☐ Yes

If ***yes***, please explain_____

e. How often do these sleep episodes occur? _____

Q17

a. Have you ever taken any recreational drugs to get high, to feel better or to change your mood over the past 3 months

*If **no**, you have completed the questionnaire – thank you very much*

b. If ***yes*,** please explain what drugs you have used and how often you use them: _____

_____

c. Do you think the use of drugs is affecting your sleep either when you are taking them or after you stop taking them?

☐ No ☐ Yes

d. Do you think the use of these drugs affect your quality of sleep (while you are using them or after you stop taking them?

☐ No ☐ Yes

If ***yes***, how many nights of the week does this affect you? _____

Thank you, this is the end of the questionnaire