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SLEEP OBSERVER SCALE

______________________________ ______________________________

Patient Name **Observer Name**

Date: Before Therapy____________________ After Therapy: ____________________

The following questions relate to the behavior that you have observed in this patient while he/she is asleep. Use the following scale to choose the most appropriate number for each situation:

0 = Never
1 = Infrequently (1 night per week)
2 = Frequently (2-3 nights per week
3 = Most of the time (4 or more nights per week)

	Before	**After**
1. Loud, obstructive or irritating snoring………………………………	_____	_____
2. Choking or gasping for air………………………………………….	_____	_____
3. Pauses in breathing………………………………………………...	_____	_____
4. Twitching/kicking of arms or legs…………………………………	_____	_____
5. Snoring requiring separate bedrooms……………………………	_____	_____
6. Falling asleep inappropriately (while driving or in a meeting, etc)	_____	_____
TOTAL SCORE	_____	_____

A score of 5 or greater indicates symptoms which are affecting the safety or quality of life of the observed person