Pioneer Neurology and Sleep

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*Name:*_____ *Date:*_____ #_____

Place a check next to the statement which indicates how you feel now. (**Check one statement only**)

1. *Wide awake; alert, functioning at a high level; head clear* _____
2. *Functioning at a high level, but not at peak; able to concentrate.* _____
3. *Relaxed; awake; not at full alertness; responsive.* _____
4. *A little foggy; not at peak; let down.* _____
5. *Fogginess, beginning to lose interest in remaining awake; slowed down.* _____
6. *Sleepiness; prefer to be lying down; fighting sleep; woozy.* _____
7. *Almost in reverie; sleep onset soon; lost struggle to stay awake.* _____

When answering the questions below, please use the following scale and circle the response that applies. 1 = Not at All 2 = Slightly 3 = Moderately 4 = Considerably

1. *How PHYSICALLY TIRING was your day today?*	*1*	*2*	*3*	*4*
2. *How MENTALLY TIRING(stressful) was your day?*	*1*	*2*	*3*	*4*
3. *How SLEEPY did you feel today?*	*1*	*2*	*3*	*4*
4. *How SICK did you feel today?*	*1*	*2*	*3*	*4*

Did anything out of the ordinary happen to you today? If so, please describe:

_____

_____

Compared to your usual evening meal, how much did you eat at your last meal?

*More*_____ *Less*_____ *Same*_____

Feel free to write down any further information/comments about your day, current state of mind, or anything else you feel is pertinent.

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