

# Sleep Observer Scale

Patient's Name \_\_\_\_\_

Observer's Name \_\_\_\_\_

Date \_\_\_\_\_

Before OAT Therapy \_\_\_\_\_

After OAT Therapy \_\_\_\_\_

The following questions relate to the behavior that you have observed in this patient while he 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)

	<u>Before</u>	<u>After</u>
1. Loud, obtrusive 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 (ex. While driving or in meetings)	_____	_____
TOTAL SCORE	_____	_____

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

© 1997, W. Keith Thornton D.D.S.