

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/she is asleep. Use the following scale to choose the most appropriate number for each situation.

0 = Never

1 = Infrequently (one night per week)

2 = Frequently (two to three nights per week)

3 = Most of the time (four or more nights per week)

	BEFORE	AFTER
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 affecting the health, safety, or quality of life of the observed person.