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.

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