



NORTHGATE OFFICE

10564 FIFTH AVE. NE
SUITE #205
SEATTLE, WASHINGTON 98125

T 206-367-2556
F 206-367-4399

KIRKLAND OFFICE

13531 JUANITA-WOODINVILLE WAY NE
KIRKLAND, WASHINGTON 98034

T 425-636-2400
F 425-636-2401

WWW.SOUNDSLEEPHEALTH.COM

REFERRAL INFORMATION

Name: _____ Date: _____

Home Phone: _____ Work Phone: _____

Referred by: _____

- Snoring or apnea
- Insomnia
- Nocturnal movements
- Other sleep issues:
- Nocturnal behaviors
- Daytime sleepiness
- CPAP management

G.A.S.P. QUESTIONNAIRE

Yes	No	Not Sure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been told (or noticed on your own) that you snore on most nights?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you tired, fatigued or sleepy on most days?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you overweight?

MEDICAL STAFF WILL FILL THIS PART OUT:

	+		0	1	2	3	4	5
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