

CENTER FOR NEUROMUSCULAR DENTISTRY
TREATMENT OF TMJ AND SLEEP DISORDERS

Sleep Observer Scale

(To be completed by patient's sleep partner.)

Date: _____

Patient's Name: _____

Observer's Name: _____

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.

Score	Frequency
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 APPLIANCE	AFTER APPLIANCE
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 (example: 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.