Form B8L: SCOPA Sleep — Participant

ADC name: _____ Subject ID: _ _ _ _ _ _ _ _ _ _ Form date: _ _ / _ _ / _ _ _ _

Visit #: _ _ _ Examiner's initials: _ _ _

INSTRUCTIONS: This form is to be completed by the participant. For additional clarification and examples, see LBD Module Coding Guidebook for Initial Visit Packet, Form B8L. Check only one box per question.

FOR CLINICIAN USE ONLY

0. Is the participant too cognitively impaired (e.g., CDR>1) to complete this form?

☐ 0 No **(CONTINUE TO ADMINISTER QUESTIONNAIRE)**

☐ 1 Yes **(END FORM HERE)**

PARTICIPANT INSTRUCTIONS

By means of this questionnaire, we would like to find out to what extent *in the past month* you have had problems with sleeping. Some of the questions are about problems with sleeping *at night*, such as, for example, not being able to fall asleep or not managing to sleep on. Another set of questions is about problems with sleeping *during the day*, such as dozing off (too) easily and having trouble staying awake.

First read these instructions before you answer the questions!

Place a cross in the box corresponding to the answer that best reflects your situation. If you wish to change an answer, fill in the "wrong" box and place a cross in the correct one. If you have been using sleeping tablets, then the answer should reflect how you have slept while taking these tablets.

Nighttime sleep				
In the past month, how often have you …	**Not at all**	**A little**	**Quite a bit**	**A lot**
1. Had trouble falling asleep when you went to bed at night	☐ 0	☐ 1	☐ 2	☐ 3
2. Felt that you have woken too often	☐ 0	☐ 1	☐ 2	☐ 3
3. Felt that you have been lying awake for too long at night	☐ 0	☐ 1	☐ 2	☐ 3
4. Felt that you have woken too early in the morning	☐ 0	☐ 1	☐ 2	☐ 3
5. Felt you have had too little sleep at night	☐ 0	☐ 1	☐ 2	☐ 3

Adapted from Marinus J, Visser M, van Hilten JJ, Lammers GJ, Stiggelbout AM. Assessment of sleep and sleepiness in Parkinson disease. SLEEP 2003;26:1049-1054. For further information, please contact Dr. J. Marinus, Leiden University Medical Center, Department of Neurology (K5Q), P.O. Box 9600, NL-2300 RC Leiden (email: j.marinus@lumc.nl).

Nighttime sleep, cont.

6. Overall, how well have you slept at night during the past month? (CHOOSE ONE):

- ☐ 1 Very well
- ☐ 2 Well
- ☐ 3 Rather well
- ☐ 4 Not well but not badly
- ☐ 5 Rather badly
- ☐ 6 Badly
- ☐ 7 Very badly

Daytime sleepiness

In the past month, how often have you …	Never	Sometimes	Regularly	Often
7. Fallen asleep unexpectedly during the day or in the evening	☐ 0	☐ 1	☐ 2	☐ 3
8. Fallen asleep while sitting peacefully	☐ 0	☐ 1	☐ 2	☐ 3
9. Fallen asleep while watching TV or reading	☐ 0	☐ 1	☐ 2	☐ 3
10. Fallen asleep while talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
11. Had trouble staying awake during the day or in the evening	☐ 0	☐ 1	☐ 2	☐ 3
12. Experienced falling asleep during the day as a problem	☐ 0	☐ 1	☐ 2	☐ 3