Wellness APEX™

Forms for Comprehensive Solution

Thank you, and Congratulations!

You've taken an important step forward in taking as much control over your health as possible. We can't change our genes. We can't erase certain disease diagnoses. But we can give our bodies what they need to do the best job only they know how to do to guide us toward healing and living our **fullest, healthiest, most vital** lives.

Optimal health is not "one size fits all". It's individual, unique, and something **only you** have in common with **you**. But we do share similar biologies, and our bodies all needs specific nutrients in order to handle specific day to day tasks.

Fortunately, with this commitment to understanding your current potential for nutrient deficiencies, you are taking the important step toward giving your body what it's specifically asking for from you. This Wellness APEX™ will provide you with significant information to help you address vital areas of health - areas you may not have known even existed until you see your results. Your results will require taking the next step, further commitment to implementing a sometimes small and sometimes large shift in diet and lifestyle, but we encourage you to take these one or two at at time.

Your Wellness APEX™ results will come with clearly defined dietary and lifestyle adjustments you can choose to implement - or not. But unlike the majority of people who want to do better - *you will know how*, and you will know how to do better *specifically* for your body. That's great news!

Let us clearly state that your Wellness APEX™ is *not* meant to be a substitute for your healthcare practitioner and it will not offer medical advice. That's for your doctor to do. Your Wellness APEX™ is an educational tool shaped by your input: your dietary information, your current roster of medications, supplements and probiotics interplay, and your lifestyle all influence how your individual body is able to absorb and utilize the nutrients you're giving it (or not). We believe education is a primary step, and through understanding we each become more aware, more confident, and more empowered to engage in our own health at levels we haven't before and in ways we didn't know we could.

Now it's time to keep this momentum going. Please **completely** fill out these forms to the best of your ability and follow the directions on each form. Send us the completed forms as soon as possible, and no later than 10 days. Once we receive your forms, you will receive a confirmation email, and we can begin processing your Wellness APEX™. Please allow up to 3 weeks for processing. **NOTE:** With the numbers of clients currently engaging in their own Wellness APEX™, we are adhering to a strict 10 day submission. If your submission is later, it will be place at the end of the list - and may take several additional weeks to be completed, so it's important to please send your forms within 10 days!

And now, let's begin! Here's to **your** WellnessMe.Life!

CLIENT PROFILE

NAME	
DATE OF BIRTH	
HEIGHT	
WEIGHT	
GENDER	

CURRENT MEDICATIONS

Please list all current medications by Brand, Dose and Frequency. If you need additional space please attach another sheet with the remainder.

BRAND (MEDICATION)	DOSE	FREQUENCY
EX: DIOVAN	160mg	2x Day, 1 in AM, 1 in PM

CURRENT SUPPLEMENTS

Please list all current supplements by Brand, Supplement/Nutrient, Dose and Frequency. If you need additional space please attach another sheet with the remainder.

BRAND	SUPPLEMENT/NUTRIENT	DOSE	FREQUENCY
EX: Centrum Silver	Multivitamin/Multimineral	N/A	1 tablet daily
EX: Solar Liquid Natural Orange	Vitamin D3	5000 IU	0.5mL 2x daily, 1 AM, 1 PM
EX: Dr. Mercola	Liposomal Vitamin C	1000 mg	2 capsules daily - AM

CURRENT PROBIOTICS, PREBIOTICS, SYNBIOTICS

Please list all current Probiotics in the two areas below. Whole foods include fermented foods (kefir, sauerkraut, greek yogurt, etc), and please include quantity. Please list supplements by Brand and Frequency. If you need additional space please attach another sheet with the remainder.
(Don't worry if you're unsure of any information - please fill out to the best of your ability.)

Whole Food or Supplement	Brand	Quantity or Dose	Frequency
EX: Whole Food	Fage Greek Yogurt, 0%	1 cup	2-3 times per week
EX: Supplement	Renew Life Ultimate Flora	15 billion live cultures per capsule, 8 strains	every other day

Detailed Instructions for the 3 Day Food Log

Please follow these directions as accurately as possible, *everything* is important. Please use 2 weekdays and 1 weekend to complete your food log.

1. **List the brand names or specific food types when possible.**
   Examples: Kraft Salad Dressing Creamy Caesar Lite - NOT, "caesar salad dressing".
   Nestle Coffee Mate Original non-dairy creamer - NOT, "cream."

2. **List the amount of food eaten using measurements as possible**
   (oz, cup, fluid ounce, tablespoon, slice, 5 nuts, 1/2 apple, etc).

3. **State how food was prepared**
   (grilled, blackened, fried, raw, chopped, boiled, etc).

Example #1: Mixed Salad w/salmon - 2 cups chopped romaine lettuce, 1/2 medium tomato, 1 small celery stalk, 5 slices cucumber, 2 tbsp Kraft Salad Dressing Creamy Caesar Lite, 1/2 cup Texas Toast Garlic Croutons, 3 oz grilled salmon (no marinade) in 1 tbsp Newman's Extra Virgin Olive Oil.

Example #2: 1 medium baked potato - 1 tbsp Kerrygold Pure Irish Butter (grass-fed), 1 tsp chives, dash of table salt and pepper

Restaurant eating: Please list the main dish meal and as many ingredients as you can identify from the menu and observation.

Record as you consume for greater accuracy.

Did you remember?
To list any supplements taken today?
To add how much water you consumed?
To list any alcohol you consumed?
To include all snacks?

WellnessME.Life

Name:				**DATE:**
3 Day Food Log				
Mealtime	**Food Item** (Include preparation - baked, boiled, grilled, fried, type of oil added, etc)	**Brand Name** (if applicable)	**Quantity** (oz, fluid ounce, cup, tsp, tbsp, etc)	**Comments** (for clarification if needed)
Day 1				
SUPPLEMENTS	DID YOU TAKE ANY SUPPLEMENTS TODAY? IF YES, PLEASE INDICATE WHICH AND HOW MANY.			
BREAKFAST				
LUNCH				
DINNER				
SNACKS (AM or PM?)				

WellnessME.Life Notes: (Please leave blank, admin only. v6.18)

WellnessME.Life

Name:				DATE:
3 Day Food Log				
Mealtime	**Food Item** (Include preparation - baked, boiled, grilled, fried, type of oil added, etc)	**Brand Name** (if applicable)	**Quantity** (oz, fluid ounce, cup, tsp, tbsp, etc)	**Comments** (for clarification if needed)
Day 2				
SUPPLEMENTS	DID YOU TAKE ANY SUPPLEMENTS TODAY? IF YES, PLEASE INDICATE WHICH AND HOW MANY.			
BREAKFAST				
LUNCH				
DINNER				
SNACKS (AM or PM?)				

WellnessME.Life Notes: (Please leave blank, admin only. v6.18)

WellnessME.Life

Name:				DATE:
3 Day Food Log				
Mealtime	**Food Item** (Include preparation - baked, boiled, grilled, fried, type of oil added, etc)	**Brand Name** (if applicable)	**Quantity** (oz, fluid ounce, cup, tsp, tbsp, etc)	**Comments** (for clarification if needed)
Day 3				
SUPPLEMENTS	DID YOU TAKE ANY SUPPLEMENTS TODAY? IF YES, PLEASE INDICATE WHICH AND HOW MANY.			
BREAKFAST				
LUNCH				
DINNER				
SNACKS (AM or PM?)				

WellnessME.Life Notes: (Please leave blank, admin only. v6.18)

MEDICAL HISTORY

Please take a little additional time with this section. This is a review of your medical history from pre-birth (gestation). Please use additional paper as necessary.

Questions to consider:

Did your mother smoke/drink while pregnant with you?
Were you born vaginally or via Caesarean?
Did you break any bones as a child?
Did you have any illnesses as a child?
Were you exposed to any significant situations (fire, car crash, serious injury) as a child?
How common is the common cold for you? How often have you gotten sick (child to adult)?
Have you been on many diets? How often? What types of diets?
Have you been treated with antibiotics? How often? What types of antiobiotics?
Have you been diagnosed with a disease? When? What was/is the treatment?
Have you had surgeries? How many/what kind?
Have you had dental amalgams (fillings)? Do you still have them?
Have you had other dental surgeries? What kind/when?
Did you have any pets growing up? Do you have pets now?
What are the significant events in your life and when were they? (Divorce, death, job loss, etc)
Were you or are you on medication for them?

Please use an additional sheet in answering these questions. Be as specific as you are comfortable to be. We respect your privacy, and as with all of your information, will not share your answers. They will be used in the summary of your medical history as a tool for you and your doctors, and to highlight key factors which may have played/are playing a role in your potential nutritional deficiencies.

ADDITIONAL FORMS

The following forms are provided by the Institute for Functional Medicine. Please complete them and return all to:

email: APEX@WellnessME.Life or

Mail: WellnessME.Life
ATTN: APEX Solutions
1275 66th St. N, Suite 40778
St. Petersburg, FL 33743

Medical Symptoms Questionnaire (MSQ)

Patient Name____ Date________________

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
- **0** – ***Never or almost never*** have the symptom
- **1** – ***Occasionally*** have it, effect is ***not severe***
- **2** – ***Occasionally*** have it, effect is ***severe***
- **3** – ***Frequently*** have it, effect is ***not severe***
- **4** – ***Frequently*** have it, effect is ***severe***

HEAD

______ Headaches
______ Faintness
______ Dizziness
______ Insomnia

Total ______

EYES

______ Watery or itchy eyes
______ Swollen, reddened or sticky eyelids
______ Bags or dark circles under eyes
______ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total ______

EARS

______ Itchy ears
______ Earaches, ear infections
______ Drainage from ear
______ Ringing in ears, hearing loss

Total ______

NOSE

______ Stuffy nose
______ Sinus problems
______ Hay fever
______ Sneezing attacks
______ Excessive mucus formation

Total ______

MOUTH/THROAT

______ Chronic coughing
______ Gagging, frequent need to clear throat
______ Sore throat, hoarseness, loss of voice
______ Swollen or discolored tongue, gums, lips
______ Canker sores

Total ______

SKIN

______ Acne
______ Hives, rashes, dry skin
______ Hair loss
______ Flushing, hot flashes
______ Excessive sweating

Total ______

HEART

______ Irregular or skipped heartbeat
______ Rapid or pounding heartbeat
______ Chest pain

Total ______

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

___________ Chest congestion
___________ Asthma, bronchitis
___________ Shortness of breath
___________ Difficulty breathing

Total ___________

DIGESTIVE TRACT

___________ Nausea, vomiting
___________ Diarrhea
___________ Constipation
___________ Bloated feeling
___________ Belching, passing gas
___________ Heartburn
___________ Intestinal/stomach pain

Total ___________

JOINTS/MUSCLE

___________ Pain or aches in joints
___________ Arthritis
___________ Stiffness or limitation of movement
___________ Pain or aches in muscles
___________ Feeling of weakness or tiredness

Total ___________

WEIGHT

___________ Binge eating/drinking
___________ Craving certain foods
___________ Excessive weight
___________ Compulsive eating
___________ Water retention
___________ Underweight

Total ___________

ENERGY/ACTIVITY

___________ Fatigue, sluggishness
___________ Apathy, lethargy
___________ Hyperactivity
___________ Restlessness

Total ___________

MIND

___________ Poor memory
___________ Confusion, poor comprehension
___________ Poor concentration
___________ Poor physical coordination
___________ Difficulty in making decisions
___________ Stuttering or stammering
___________ Slurred speech
___________ Learning disabilities

Total ___________

EMOTIONS

___________ Mood swings
___________ Anxiety, fear, nervousness
___________ Anger, irritability, aggressiveness
___________ Depression

Total ___________

OTHER

___________ Frequent illness
___________ Frequent or urgent urination
___________ Genital itch or discharge

Total ___________

Grand Total ___________

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Toxin Exposure Questionnaire (TEQ-20)

Patient Name____ Date____________________

Please check YES or NO for each of the following questions. Your provider will discuss your answers with you.

QUESTIONS	YES	NO
1. Do you consume conventionally grown (non-organic) fruits and vegetables regularly? If so, which ones do you eat most often? ________________	☐	☐
2. Do you consume conventionally raised animal products (meat, dairy, eggs) regularly? If so, which ones do you eat most often? ________________	☐	☐
3. Do you consume fish or seafood more than twice a week? If so, please describe what you eat and whether it is farmed or wild. ________________	☐	☐
4. Do you consume fast foods, canned/packaged foods, soda, or foods with artificial colors, flavors, preservatives or sweeteners more than three times a week?	☐	☐
5. Have you lived in a mobile home, boat, or RV, or a very old or brand-new home? If so, please describe: ________________	☐	☐
6. Have you recently been exposed to new construction materials or furniture (e.g., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	☐	☐
7. Does your home or workplace have cracking paint or decaying insulation or foam, visible mold, water damage, or damp windows, basement, or crawlspaces?	☐	☐
8. Are you often exposed to adhesives, paints, flea treatments, varnishes, solvents, welding/soldering materials, or other air-borne chemicals at home or work?	☐	☐
9. Have you been exposed to treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, or other toxic substances you know of?	☐	☐
10. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	☐	☐
11. Do you regularly use conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	☐	☐
12. Are your health concerns related to time spent living or working adjacent to a highway, factory, incinerator, gas station, power plant, or other industrial pollution source?	☐	☐
13. Have you lived in an agricultural area or often been exposed to herbicides, pesticides, fungicides at home, work, parks & golf courses, or roadsides?	☐	☐
14. Do you live near a cell phone tower, high-voltage power lines, or other known source of electromagnetic radiation?	☐	☐
15. Do you live or work in a sealed building with recirculated air or a building that has wood, propane, or gas stoves or appliances?	☐	☐
16. Do you smoke or are often exposed to second-hand smoke, fly often, or run or bike to work along busy streets?	☐	☐
17. Are you highly sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes? If so, please explain: ________________	☐	☐
18. Have you had root canals, tooth extractions, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	☐	☐
19. Have you had any unusual reactions to anesthesia or to prescription or over-the-counter medications? If so, please describe: ________________	☐	☐
20. Do you have a history of heavy use of alcohol or recreational or prescription drugs? If so, please describe or discuss with your provider: ________________	☐	☐

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Sleep Questionnaire

Patient Name____ Date____________________

Sleep is important for healing, immunity, mood, cognition, and many other physiological functions.

Please answer the following questions as accurately and fully as possible. For Yes / No questions, please check the correct answer and provide an explanation if one is requested. The information will help to determine whether you are getting the sleep you need and to identify possible strategies to help you sleep better.

Sleep Problems:

1. Do you have a sleep problem that has been diagnosed? ☐ Yes ☐ No
   If yes, what?____
2. Do you feel that you have a sleep problem? ☐ Yes ☐ No
   If yes, how would you describe it? ____
   Do you snore loudly or stop breathing while you sleep? ☐ Yes ☐ No
   Have you had a sleep study performed? ☐ Yes ☐ No
   Do you use a CPAP machine? ☐ Yes ☐ No

Sleepiness Questions:

3. Do you feel well rested in the morning? ☐ Yes ☐ No
4. Are there times during the day or evening that you feel sleepy? ☐ Yes ☐ No
   If yes, what times are these?____
5. What do you do to wake up when you feel sleepy? ____
6. Have you ever had an accident at work, at home or on your job because you were sleepy? ☐ Yes ☐ No
   If yes, please explain ____
7. Do you take naps? ☐ Yes ☐ No
   If yes, for how many minutes and at what time of day? ____
8. Do you feel well rested after a nap? ☐ Yes ☐ No

Insomnia Questions:

9. Can you usually fall asleep within 20 minutes of lying in bed? ☐ Yes ☐ No
   If not, how long does it take? ____
10. If it takes longer than 20 minutes, what do you do while trying to fall asleep?
    (e.g., read, watch TV, look at phone, get up, etc.)____
11. Do you ever feel so wired at night that it is difficult to fall asleep? ☐ Yes ☐ No
12. Have you had a saliva cortisol test? ☐ Yes ☐ No
    If yes, what was your night time level? ____

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Self-Care Questionnaire

Patient Name____ Date____________________

Research shows that people who take time to recharge and restore are more creative, happier, and more successful. This questionnaire will help you identify the areas of your life that are well-tended, and those that could use more time and attention. This is not meant to be a diagnostic assessment. Instead, it is a tool to help you see what you are doing to care for yourself. There are no right or wrong answers to these questions, and some of them may require a bit of thought. Take your time and answer each question to the best of your ability based on your self-care practices right now.

For the following questions, please rank each item on a scale of 0-5.

0 - Never 1 - Rarely 2 - Sometimes 3 - Often 4 - Regularly 5 - Always

PHYSICAL WELLBEING—How often do you:	Rating Scale
1. Eat a whole foods-based diet rich in colorful fruits and vegetables?	0 1 2 3 4 5
2. Drink enough water?	0 1 2 3 4 5
3. Exercise for more than 20 minutes?	0 1 2 3 4 5
4. Wake feeling refreshed from sleep?	0 1 2 3 4 5
5. Sleep at least 7 hours per night?	0 1 2 3 4 5
6. Make time to relax or nap?	0 1 2 3 4 5
7. Take time to breathe deeply throughout the day?	0 1 2 3 4 5
8. Engage in stress-reducing activities (excluding TV or screen time)?	0 1 2 3 4 5
9. Spend time in nature?	0 1 2 3 4 5
10. Feel nourished, healthy, and strong?	0 1 2 3 4 5
MENTAL/EMOTIONAL/SPIRITUAL WELLBEING—Do you:	
1. Make time to participate in things you enjoy?	0 1 2 3 4 5
2. Give and receive affection regularly?	0 1 2 3 4 5
3. Feel understood and valued by those who are close to you?	0 1 2 3 4 5
4. Feel gratitude on a daily basis?	0 1 2 3 4 5
5. Find meaning in life even during difficult times?	0 1 2 3 4 5
6. Take an interest in or find joy in the world around you?	0 1 2 3 4 5
7. Have hope that things will get better?	0 1 2 3 4 5
8. Express yourself creatively?	0 1 2 3 4 5
9. Treat yourself with kindness?	0 1 2 3 4 5
10. Remember to make your dreams and goals a priority?	0 1 2 3 4 5

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For the following questions, please rank each item on a scale of 0-5.

0 - Never 1 - Rarely 2 - Sometimes 3 - Often 4 - Regularly 5 - Always

PROFESSIONAL LIFE/WORK/CAREER—Do you:	Rating Scale					
1. Hold a work position in an area of your interest?	0	1	2	3	4	5
2. Work in a position that matches your professional goals?	0	1	2	3	4	5
3. Find a sense of meaning and enjoyment in your work?	0	1	2	3	4	5
4. Empathize and connect with customers, clients, and work colleagues?	0	1	2	3	4	5
5. Have confidence in your ability to address challenges in your professional life?	0	1	2	3	4	5
6. Feel supported at work or in your professional life?	0	1	2	3	4	5
7. Have someone you can rely on if you need help or guidance?	0	1	2	3	4	5
8. Set limits at work, whether it be with clients or tasks?	0	1	2	3	4	5
9. Disengage and leave pressures behind at the end of the day?	0	1	2	3	4	5
10. Take vacation or holiday breaks to allow for some down time?	0	1	2	3	4	5
SOCIAL LIFE/FAMILY/RELATIONSHIPS—Do you:						
1. Have a dependable person who listens to you?	0	1	2	3	4	5
2. Have supportive family and friends close by?	0	1	2	3	4	5
3. Get enough social time with people who make you happy?	0	1	2	3	4	5
4. Participate in group activities with people who share a common interest?	0	1	2	3	4	5
5. Spend time with people who make you laugh?	0	1	2	3	4	5
6. Feel like your close relationships are loving and supportive?	0	1	2	3	4	5
7. Have the ability to comfortably say no?	0	1	2	3	4	5
8. Do something fun with family or friends at least once a week?	0	1	2	3	4	5
9. Feel like your personal life brings balance to your professional life?	0	1	2	3	4	5
10. Feel comfortable asking for help when you need it?	0	1	2	3	4	5

The higher the score, the better you may be at taking time for self-care and wellness in each aspect of your life. Trying to improve your scores can help create more balance in your life.

Consider items on which you scored 3 or lower. How can you modify your behavior to improve your self-care practices? What goals might you need to set in order to make these changes?

____

____

____

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Insomnia Questions:

13 Do you currently take, or have you tried, any of the following sleep aids to fall asleep? ☐ Yes ☐ No
If yes, how many times per week do you take them? Please answer with an **E** for effective or an **N** for not effective in helping you to sleep:

Sleep Aids	Tried in the past?	Taking now?	Dosage?	E or N?
Ambien (zolpidem)				
Sonata (zaleplon)				
Lunesta (eszopiclone)				
Belsomra (suvorexant)				
Valium (diazepam)				
Ativan (lorazepam)				
Restoril (temazepam)				
Tylenol PM				
Benadryl				
Calcium/Magnesium				
Valerian				
Kava				
Melatonin				
5-HTP				
Others				

14 Do you wake up in the middle of the night? ☐ Yes ☐ No
If yes, how many times and for what reasons? ________________________________

15 Do you have any trouble falling back asleep when you wake up? ☐ Yes ☐ No
If yes, how long does it usually take you? ________________________________

16 Does feeling the need to move your feet or legs at night keep you awake or have you been diagnosed with Restless Legs Syndrome? ☐ Yes ☐ No

17 Do you have disturbing dreams at night? ☐ Yes ☐ No

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Caffeine and Other Stimulants:

18 If you drink or eat any of the following, please indicate how much (number of ounces, cups, glasses, etc.), how often per day, and at what times per day?

Do you use...	How much?	How often per day?	When during the day?
Coffee			
Caffeinated sodas *(Coke, Pepsi, Mountain Dew, etc.)*			
Caffeinated water			
Green tea			
Black tea			
Other tea			
Chocolate			
Coffee or espresso ice creams			
Sudafed or other OTC cold medications			
Alcohol			

19 What medications are you on and what time do you take them?

____

____

Stress and Stress Reduction:

20 What kind of stress have you been under in the past few months?______________________

21 What do you do for stress management? ______________________

22 Do you have a journal to write in that is near your bed? ☐ Yes ☐ No

23 Do you exercise aerobically? ☐ Yes ☐ No
If yes, what do you do, how often do you exercise, and at what time of day?______________________

____

Sleep Hygiene:

24 What time do you usually go to bed?______________ What time do you usually wake up?______________

25 Do you feel that you go to bed too late? ☐ Yes ☐ No
If yes, what time would you like to go to bed?______________________

26 Do you watch TV in the evenings ☐ Yes ☐ No
If yes, what hours do you watch it?______________________

27 Is the TV in your bedroom or in a family room? ______________________

28 Do you use a tablet, cell phone or other electronic devices while lying in bed before going to sleep? ☐ Yes ☐ No

29 Do you read in bed before trying to fall asleep? ☐ Yes ☐ No
If yes, do you use a light or read on a tablet or phone that has a lit up screen? ☐ Yes ☐ No

30 Do you wear or use a sleep monitoring device? ☐ Yes ☐ No
If yes, what type?______________________

31 How many hours are you physically in your bed? ______________________

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Sleep Hygiene:

32 How many hours of the time spent in bed are you actually asleep? ____________________

33 On the weekend or days off do you vary your sleep schedule? ☐ Yes ☐ No

34 Do you have much light coming into your bedroom? ☐ Yes ☐ No
If yes, what is the source? ____________________

35 Do you have young children who wake you up? ☐ Yes ☐ No

Bedroom, Breathing and Environment:

36 Are there any unusual smells in your bedroom? ☐ Yes ☐ No
If yes, please describe____________________

37 Do you use Breathe-Easy strips on your nose? ☐ Yes ☐ No If yes, do they help you to breath? ☐ Yes ☐ No

38 Do you have carpets or hardwood floors in your bed room? ____________________

39 How many rooms in your home have carpets and how old are the carpets? ____________________

40 What type of heat is in your home: forced air or radiant? ____________________

41 How often do you change the furnace filter in your home?____________________

42 Have you seen any black mold in your window sills or in a basement? ☐ Yes ☐ No

43 Do you have a HEPA air filter for your bedroom? ☐ Yes ☐ No
If yes, what brand is it and how long do you run it each day? ____________________

44 What type of vacuum cleaner do you use and does it have a HEPA filter in it?____________________

45 How often do you clean the dust in your bedroom? ____________________

46 Do you sleep with an animal that snores or moves around and disturbs you? ☐ Yes ☐ No

47 Do you sleep with a bed partner who snores, moves around at night or disturbs you when you are trying to sleep?
☐ Yes ☐ No

48 Do noises wake you up? ☐ Yes ☐ No
If yes, what are they?____________________

49 Do you live on a noisy street? ☐ Yes ☐ No

50 Do you feel safe in your bed at night? ☐ Yes ☐ No
If not, explain ____________________

Bed, Pillows, and Pain:

51 What type of bed do you have and what size is it?____________________

52 Do you wake up because of pain? ☐ Yes ☐ No
If yes, at what time and where is the pain? ____________________

53 What type of pillow is most comfortable for you and what type have you tried that did not work?

____

54 Do you use body pillows? ☐ Yes ☐ No
If yes, how many and how do you use them? ____________________

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