

REM Sleep Behavior Disorder Screening Questionnaire

Please answer each question by checking the appropriate box

		YES	NO
1.	I sometimes have very vivid dreams	<input type="checkbox"/>	<input type="checkbox"/>
2.	My dreams often have aggressive or action-packed content	<input type="checkbox"/>	<input type="checkbox"/>
3.	The dream content mostly matches my nocturnal behavior	<input type="checkbox"/>	<input type="checkbox"/>
4.	I know that I move my arms or my legs in my sleep	<input type="checkbox"/>	<input type="checkbox"/>
5.	When this has happened, I have sometimes (almost) hurt my sleeping partner or myself	<input type="checkbox"/>	<input type="checkbox"/>
6.	I experience or have experienced the following phenomena during my dreams:		
	6.1 speaking, shouting, swearing, laughing loudly	<input type="checkbox"/>	<input type="checkbox"/>
	6.2 sudden limb movements, "fights"	<input type="checkbox"/>	<input type="checkbox"/>
	6.3 gestures, sequences of movements that are pointless during sleep, e.g. waving, saluting, shooing away a fly, falling out of bed	<input type="checkbox"/>	<input type="checkbox"/>
	6.4 things that have fallen down around the bed, e.g. bedside lamp, book, glasses	<input type="checkbox"/>	<input type="checkbox"/>
7.	At times I'm woken up by my own movements	<input type="checkbox"/>	<input type="checkbox"/>
8.	On waking up, I can usually remember the content of my dreams well	<input type="checkbox"/>	<input type="checkbox"/>
9.	My sleep is often disturbed	<input type="checkbox"/>	<input type="checkbox"/>
10.	I have/have had a disease of the nervous system (e.g. stroke, head trauma, Parkinson's Disease, RLS, narcolepsy, depression, epilepsy, inflammatory disease of the brain). If so, which one?	<input type="checkbox"/>	<input type="checkbox"/>

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