Sleep Questionnaire

Name: _____ **Date:** _____

Sleep is important for musculoskeletal healing and for healthy immune function, mood, cognitive and brain function, and many physiological functions. Please answer the following questions as accurately and fully as possible. For Yes/No questions, please circle 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
2. Do you feel that you have a sleep problem? Yes/No If yes, how would you describe it? _____
   _____

Sleepiness

3. Do you feel well rested in the morning? Yes/No Please explain:_____
4. Are there times during the day or evening that you feel sleepy? Yes/No If yes, what times? _____
   _____
5. What do you do to wake up when you feel sleepy?_____
6. Have you ever had an accident at work or at home 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

9. Can you usually fall asleep within 20 minutes of lying in bed? Yes/No
10. How long does it usually take you to fall asleep? _____
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, was your night time level high? Yes/No
13. Do you now take (or have you tried) any of the following to fall asleep? Yes/No If yes, please complete the chart below.

Sleep Aid	Tried in the past? (√)	Taking now? (√)	Dosage and how many times per week?	Effective? (Enter Y or N)
Ambien®				
Sonata®				
Valium®				
Ativan®				
Restoril®				
Calcium/Magnesium				
Valerian				
Kava				
Melatonin				

Other? (Please specify) _____				

14. Do you wake up in the middle of the night? Yes/No If so, 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

Caffeine and Other Stimulants

18. Do you eat, drink, or use any of the following? Yes/No If yes, please complete the chart below.

Item	How much per day? (cups, glasses, ounces, etc.)	When during the day?
Coffee		
Caffeinated sodas		
Caffeinated water		
Green tea		
Black tea		
Other tea		
Chocolate		
Coffee or espresso ice cream		
Sudafed or other cold medications		
Alcohol		

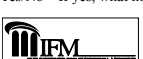
19. What medications are you on, and what time do you take them? _____
_____
_____

Stress and Stress Reduction

20. What kind of stress have you experienced 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 do aerobic exercise? 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? _____
25. What time do you usually wake up? _____
26. Do you feel that you go to bed too late? Yes/No If yes, what time would you like to go to bed? _____
27. Do you watch TV in the evenings? Yes/No If yes, what hours do you watch it? _____



28. Is the TV in your bedroom or in a family room? _____
29. On the weekend or days off, do you vary your sleep schedule? Yes/No
30. How many hours are you physically in your bed? _____
31. How many hours of the time spent in bed are you actually asleep? _____
32. Do you have much light coming into your bedroom? Yes/No
33. What can you see at night without any lights on? _____
34. Do you have young children who wake you up? Yes/No

Bedroom, Breathing, and Environment

35. Is the air in your bedroom clean or dirty? _____
36. Are there any unusual smells in your bedroom? Yes/No If yes, please describe: _____
37. Do you snore, stop breathing, or have trouble breathing at night? Yes/No
38. Do you use nasal strips to help you breathe? Yes/No If yes, are they effective? Yes/No
39. Do you have carpets or hardwood floors in your bedroom? _____
40. How many rooms in your home have carpets and how old are the carpets? _____
41. What type of heat is in your home: forced air or radiant? _____
42. How often do you change the furnace filter in your home? _____
43. Have you seen any black mold in your window sills or in the basement? Yes/No
44. 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? _____
45. What type of vacuum cleaner do you use and does it have a HEPA filter in it? _____
_____
46. How often do you clean the dust in your bedroom? _____
47. Do you sleep with an animal that snores or moves around and disturbs you? Yes/No
48. Do you sleep with a bed partner who snores, moves around at night or disturbs you when you are trying to sleep? Yes/No
49. Do noises wake you up? Yes/No If so, what are they? _____
50. Do you live on a noisy street? Yes/No
51. Do you feel safe in your bed at night? Yes/No

Bed, Pillows, and Pain

52. What type of bed do you have and what size is it? _____
53. Do you wake up because of pain? Yes/No If yes, what time and where is the pain? _____
_____
54. What type of pillow is most comfortable for you and what type have you tried that did not work? ___
_____
55. Do you use body pillows? Yes/No If yes, how many and how do you use them? _____
_____