SLEEP ASSESSMENT

Name _____ **Occupation** _____ **Date** _____

1. How's your sleep?

Excellent	Very good	Good	Fair	Poor

2. What time do you usually go to bed?

9pm-10pm	10pm-1pm	11pm-midnight	After midnight	Other _____

3. What time do you usually wake up?

Before 5am	5am-6am	6am-7am	7am-8am	After 8am

4. What time of day do you feel most alert and productive?

Early morning	Mid-morning	Afternoon	Late afternoon	Evening

5. What kind of activities do you usually do before you go to bed?

Finish daily tasks	Watch TV, browse internet	Read books, journal	Interact with family, friends	Exercise

Other (please specify) _____

6. Do you do any of the following before bed?

Consume caffeine	Eat	Drink alcohol	Smoke	Take sleeping pills

7. Are any of those factors present in your bedroom when you go to bed?

Temperature over 70 degrees	Bright lights	Loud sounds	Very warm bedding	Pets or children in your bed

8. How long does it take you to fall asleep?

Less than 15 min	15-30 min	30-45 min	45-60 min	1 hour or longer

9. Do you wake up during the night? ☐Yes ☐Sometimes ☐Not usually
   If you do, please answer the following:
   How many times? _____
   Is there an obvious reason? _____
   How long does it usually take you to fall back asleep?

10. Do you wake up earlier than you would like? ☐Yes ☐Sometimes ☐Not usually
    If you do, please answer the following:
    How often? _____
    What do you do when it happens? ☐Stay in bed ☐Get up

11. How many times a week do you have problems with your sleep?

Not every week	0-1	2-3	4-5	6-7

12. Have you ever been diagnosed with any sleeping disorder? If yes, what kind? Did you have treatment?

13. Does the quality of your sleep seem to affect your... (circle all that apply)

Mood	Energy	Health	Concentration	Relationships

14. How do you feel about sleep? _____