Sleep Questionnaire

Patient Name: ______________________

1. Rate your sleep quality. Check all that apply

❑ Wake up tired ❑ Nightmares/Terrors ❑ Restless Legs ❑ Teeth grinding/Tongue biting

❑ Sleep Apnea ❑ Snoring ❑ Difficulty falling asleep ❑ Toss & turn

❑ Sleep walk ❑ Sleep talk ❑ Wake up during the night (usually at: ____)

❑ Other: ______________

2. What time do you usually go to sleep on weekdays (workdays)? ________ Hours do you sleep per night? ________

What time do you usually go to sleep on weekends (days off)? ________ _ Hours do you sleep per night? ________

3. How long does it take you to go to sleep?

❑ 0-5 minutes ❑ 5-15 minutes ❑ 15-30 minutes ❑ 30-60 minutes ❑ 60+ minutes

4. How long has this been happening?

❑ Less than 1 month ❑ Longer than 1 month

5. How long do you stay asleep?

❑ Just minutes ❑ 1-2 hours, wake up, but then return to bed ❑ Awake nightly at 3 am (2:30-3:30am)

Number of times I wake up on a given night: _________

6. How long could you sleep if left undisturbed?

❑ <7 hours ❑ 7-8 hours ❑ 9-11 hours ❑ 11+ hours

7. My sleep position is:

❑ On Back ❑ On Stomach ❑ On Side ❑ No single position is used

8. When do you feel hungry after you awaken?

❑ Within 30 minutes or less ❑ Between 30 minutes to 2 hours ❑ 2 or more hours after waking

9. How often do you take a nap during the day?

❑ Never ❑ Once a week ❑ Twice a week ❑ 3+ times a week

How long is a typical nap? ____________________ What time of day is the nap? ________________________

10. Have you had an Adrenal Stress Index (ASI) saliva test performed? ❑ Yes ❑ No ❑ I don't know

11. Do you take sleep medications or supplements? ❑ No ❑ Yes (List names & how long you've taken them)

Medication/Supplement Name	# of days per week used	Date Started/Stopped	Dosage