Sleep History

How satisfied are you with your sleep? Horrible __ Bad __ Fair __

When did this problem first start? ________

When was the last time you slept well? ________

What have you tried to help you sleep? ________________________

(Write more on back if needed)

EVENING

• What time is your last food? ________
• What time is your last drink? ________
• What time is your last caffeine? ________
• What time is your last tobacco? ________
• What time is your last screen? ________ TV / Computer / Phone / Tablet / Other

What do you usually do before bed?

☐ Exercise ☐ Work on Computer, Phone ☐ Other
☐ Watch TV ☐ Read a book or Tablet.

SLEEP

What time do you usually get in bed to go to sleep?

☐ Before 8pm ☐ 8-9 pm ☐ 9-10 pm ☐ 10-11 pm ☐ 11-12 am ☐ after 12 am

How long until you usually fall asleep?

☐ Less than 15 minutes ☐ About 30 minutes ☐ If longer then 60 minutes, what is happening?
☐ About 15 minutes ☐ about 60 minutes

When is the next time you wake up? ________ How many times are you up at night? ________

Why do you wake up?

☐ Pain ☐ Room Temperature
☐ Have to use the restroom ☐ Animals
☐ Partner moving or snoring ☐ Thoughts Racing
☐ Room is Too Light ☐ Body moving
☐ Noise/Sounds ☐ Other? ______________________

How long does it take you to get back to sleep? ________

Sleep Preferences and Information

• What position do you usually sleep? side, back, stomach, other
• Do you snore? Yes ☐ No ☐ Unknown
• Is your mattress and pillow comfortable? Yes ☐ No
• How many pillows do you use? ________
• Is your house a comfortable temperature? Yes  No  Do you know what temperature? _____
• Anything else about your Sleep Environment? ________
• Anything else about your Sleep Habits, Body, Emotions, Thoughts or Stress? ________

MORNING
• What time do you wake up in the morning? ________
• What time do you get out of bed? ________
• Do you wake up rested? ________ If no, please explain:
• Do you use a snooze alarm? Yes  No

DAY TIME
• How is your energy during the day? Poor-Fair-Good-Great
• Do you take naps? ________ How many and for how long? ________
• Do you drink caffeine? ________ Time of Last caffeine ________?
• Do you smoke? ________ Tobacco/Marijuana/Other ________?

Your Thoughts and Emotions
• How is your stress level? Low / Medium / High
• Do you do anything to help relax during the day?  Y  N  If so, what do you do? ______

Anything else you think we should know?

___________________________________________________________________________

Provider Notes:

Cardinal Symptom: ________
Rating Scale:  B  /10  /7 =
  W  /10  /7 =
  A  /10  /7 = ______

Score: ______

Behaviors to Modify:
• Habits:
• Body:
• Environment:
• Thoughts and Emotions: