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
- ❒ Watch TV
- ❒ Read a book
- ❒ Work on Computer, Phone or Tablet.
- ❒ Other _____

SLEEP

What time to 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 15 minutes
- ❒ About 30 minutes
- ❒ about 60 minutes
- ❒ If longer then 60 minutes, what is happening?

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

Why do you wake up?

- ❒ Pain
- ❒ Have to use the restroom
- ❒ Partner moving or snoring
- ❒ Room is Too Light
- ❒ Noise/Sounds
- ❒ Room Temperature
- ❒ Animals
- ❒ Thoughts Racing
- ❒ Body moving
- ❒ 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: