SLEEP ASSESSMENT SCALE

Patient's Name: _____ Today's Date: _____

GENERAL INFORMATION ABOUT YOUR SLEEP:

1. How many hours per night would be the ideal amount for you?_____hours
2. About how many hours per night are you currently sleeping?_____hours
3. What would be your ideal bedtime?_____

Instruction to patient: Below is a list of problems and complaints that patients sometimes experience. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in *the last 2 weeks*.

No.	Response:	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)
1.	Do you have ***trouble falling asleep*** (takes longer than 20 minutes)?					
2.	After falling asleep, do you ***awaken in the middle of the night***?					
3.	Are you troubled with ***distressing dreams or nightmares***?					
4.	Do you have feelings of ***restlessness or unwanted body movements*** while trying to sleep?					
5.	Do you ***snore***?					
6.	Do you have ***problems breathing*** at night or have you been told you ***pause breathing*** while you are sleeping?					
7.	Do you ***talk or walk*** in your sleep?					
8.	Do you have ***difficulty waking up*** and getting out of bed?					
9.	After a typical night's sleep do you still feel like you ***haven't rested*** or are ***not refreshed***?					
10.	Do you have ***daytime sleepiness***?					
11.	Do you have ***difficulty concentrating*** because you are too tired?					
12.	Do you take ***naps***?					
13.	Does your ***bed-time*** vary by more than 1 hour?					
14.	Does your ***wake-time*** vary by more than 1 hour?					
15.	Do you use any type of ***sleep-aid*** such as alcohol, tea, over-the-counter sedatives, or nutritional supplements?					
16.	Do you use ***caffeinated*** beverages such as coffee, tea, or soda pop?					
17.	Are you concerned about your safety, comfort, or security in your ***sleeping quarters***?					
	Totals:					

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