Patient Name: _____ Date of Birth: _____ Date: _____

Sleep Evaluation

Sleep is a biological need that is vital to your treatment for maintaining optimal health.
Your responses will be evaluated and monitored as part of your personal treatment plan.

On a typical night in the last month…

1. How many hours of sleep did you get? _____

2. How many minutes does it typically take you to fall asleep? _____

3. Which activities did you do in bed before going to sleep?
   (Check all that apply)
   - ☐ Watched TV
   - ☐ Read a book or magazine
   - ☐ Listened to music
   - ☐ Looked at a tablet or smartphone
   - ☐ None

4. Was your sleep interrupted during the night? For how many minutes in total?
   - ☐ My sleep was not interrupted
   - ☐ I was awake for less than 5 minutes
   - ☐ I was awake for 5-15 minutes
   - ☐ I was awake for more than 15 minutes

5. Did you wake up in the morning with:
   (Check all that apply)
   - ☐ lower back pain
   - ☐ neck pain
   - ☐ tingling in your fingers
   - ☐ headache
   - ☐ other _____

6. In which position did you sleep most often?
   ☐ Stomach ☐ Back ☐ Side

7. How many pillows did you use to sleep? _____

8. How old is your mattress?
   ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ Over 10 years

9. What type of mattress do you sleep on?
   ☐ An innerspring mattress ☐ A foam mattress ☐ Other _____