**Initial Assessment & 7-day Sleep Performance Journal**

Instructions: Welcome to step 1 of improving your rest, sleep & recovery and overall quality of life. Please fill in below; if you prefer to print and write, feel free. Otherwise, you may use word functions such as typing and highlighting to complete the worksheet. Once completed, please send it back to your therapist as soon as possible. Your therapist will evaluate your work, and schedule a telehealth appointment with you to review answers and come up with a custom sleep plan.

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| --- | --- |
| **Name:** **Marital Status:****Brand of Mattress & Year Purchased:****How dark is your room?****1………….2………….3………….4………….5****How quiet is your room?****1………….2………….3………….4………….5****What temperature are you most comfortable sleeping at?** **Are you a “hot” sleeper (ie. you sweat) or a “cold” sleeper (ie. you need multiple blankets to stay warm, or in between?****Do you have a TV in your room?****Do you charge your phone in your room?****How many hours, on average, are you IN BED at night?** **Do you drink alcohol at night, if so, how often and what is the amount?****Are you a caffeine drinker?** | **Age:****Do you co-share your bed?** **How comfortable do you find your mattress?****1………….2………….3………….4………….5****Hate it. It’s fine. It’s the best.****Do you do anything to make the room darker, such as blackout curtains or sleep mask? If so, describe:****Do you do anything to decrease noise/distractions?****Is your room typically kept at this temperature when you are sleeping?****What type of sheets and blankets do you use?****Do you like to watch TV in your room before falling asleep?****Do you find yourself checking emails, scrolling social media etc. before falling asleep?****How many hours do you think you get quality sleep?****Do you exercise? If so, what kind of exercise, how frequently (weekly), and at what time during the day?****How many cups per day, and what kind (coffee, energy drink etc.)** |

**For the next questions, please be as descriptive as possible.**

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| **What do you think are some main causes of your sleep challenges?** |
| **How do you feel when you wake up?** |
| **Have you tried any supplements, medications etc.?** |
| **Please provide any additional information that you’d like your therapist to know about your sleep environment, pattern, quantity, quality etc.** |

**My Sleep Journal**

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| **Day** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| Please record exercise type, length, and time | Ex: CROSSFIT Arms/upper body; 50 mins; 12P-1P |  |  |  |  |  |  |
| Please record what you had for dinner/drinks, and time | Ex: 6PM-6:30 PMSalmon with about a cup of broccoli, 1 glass red wine, 1 glass water, 9 PM: sonic ice cream blast |  |  |  |  |  |  |
| What are 3-4 things you did right before getting into bed? | **(TIME)** Teeth**(TIME)** PJs**(TIME)** Phone x 45 mins**(TIME)** In Bed | **(TIME)** **(TIME)** **(TIME)** **(TIME) In Bed** | **(TIME)** **(TIME)** **(TIME)** **(TIME) In Bed** | **(TIME)** **(TIME)** **(TIME)** **(TIME) In Bed** | **(TIME)** **(TIME)** **(TIME)** **(TIME) In Bed** | **(TIME)** **(TIME)** **(TIME)** **(TIME) In Bed** | **(TIME)** **(TIME)** **(TIME)** **(TIME) In Bed** |
| What did you do right before falling asleep and/or to fall back asleep? | Ex: Tossed & Turned until 1AM, looked at my phone for 10 mins, got a snack, fell asleep. |  |  |  |  |  |  |
| How many hours were you in bed & how many hours did you sleep? | **In Bed:** 8**Sleep:** 5.5 | **In Bed:** **Sleep:**  | **In Bed:** **Sleep:** | **In Bed:** **Sleep:** | **In Bed:** **Sleep:** | **In Bed:** **Sleep:** | **In Bed:** **Sleep:** |
| How did you feel when you woke up AND throughout the day  | Ex: Already up when alarm went off, felt awake. Crashed at 11, needed energy drink for a boost; felt foggy all day & easily angered  |  |  |  |  |  |  |