

Sleep Assessment

GETTING STARTED

	Very poor health	Excellent health
a. Please circle your current overall LEVEL OF HEALTH .	0 1 2 3 4 5 6 7 8 9 10	
b. Please rank the top 3 areas you would like to improve with 1 being the most important and 3 the least important.		
Sleep _____	Weight Management _____	Nutrition _____
Exercise _____	Purpose & Connection _____	Mental Health _____
Substance Use _____		
	Not important at all	Very important
c. How IMPORTANT is it for you to make the change you ranked as the #1 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
d. How CONFIDENT are you regarding your ability to make the change you ranked as the #1 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
e. How IMPORTANT is it for you to make the change you ranked as the #2 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
f. How CONFIDENT are you regarding your ability to make the change you ranked as the #2 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
g. How IMPORTANT is it for you to make the change you ranked as the #3 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
h. How CONFIDENT are you regarding your ability to make the change you ranked as the #3 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
i. What would you like to gain from this lifestyle visit? <i>Check all that apply</i>		
<input type="checkbox"/> More medical/scientific knowledge	<input type="checkbox"/> Practical health tips	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Accountability	<input type="checkbox"/> Personalized plan	

Patient Name: _____ DOB: _____

SLEEP

Please answer based on your sleeping patterns OVER the LAST TWO WEEKS

	Never	Seldom	Sometimes	Often	Always
a. How often have you had difficulty staying awake during routine tasks?	1	2	3	4	5
b. How often have you had difficulty staying awake while driving?	1	2	3	4	5
c. How often have you felt fatigued or needed to nap during the day?	1	2	3	4	5
d. How often has it taken you more than 30 minutes to fall asleep at night?	1	2	3	4	5
e. How often have you woken up at night?	1	2	3	4	5
f. How often have you unintentionally woken up early in the morning?	1	2	3	4	5
g. How often do you look at a screen within 2 hours of sleeping (i.e. TV, computer, iPad, or Phone)?	1	2	3	4	5
h. How often have your legs or arms jerked during sleep?	1	2	3	4	5
i. How often have you experienced "creeping" or "crawling" feelings in your legs?	1	2	3	4	5
j. How often have you snored loudly, gasped, choked, or stopped breathing during sleep?	1	2	3	4	5
k. How often have you used sleeping aids (i.e. tobacco, alcohol, over-the-counter medications, or prescription medications) to help you fall asleep?	1	2	3	4	5
l. Do you have a job that requires night shifts?	1	2	3	4	5
m. Do you have a medical condition or chronic pain that interferes with your sleep?	1	2	3	4	5
n. On an average weekday do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5
o. On an average weekend do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5

Patient Name: _____ DOB: _____