Sleep assessment tool

ALL INFORMATION PROVIDED IS TREATED AS CONFIDENTIAL

Name:………………………………………………………………………………

Tel No:………………………………………..Date of Birth:……………………

About your sleep

How many hours sleep do you get each night?

Less than 2 hours	2-4 hours	4-6 hours	6 or more hours

During the last month how many times have you felt refreshed when you wake up in the morning?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

During a typical month do you get good quality deep sleep, or is your mind still alert during sleep?

Always good quality	Mostly good quality	Equal amount of good and poor quality	Mostly poor quality	Always poor quality

During the last month how often have you had difficulty sleeping because:

a. You could not get to sleep within 30 minutes?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

b. You wake up in the middle of the night or early morning?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

c. You have to get up to use the bathroom?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

d. You snore, gasp for air, or stop breathing?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

e. You kick or thrash about while asleep?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

f. You are in pain?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

g. The room is too light, noisy, hot or cold?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

Please list any other reasons:

………………………………………………………………………………………………

How often did these reasons affect your sleep in the last month?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

How many times during the last month have you had difficulty staying awake whilst driving, eating or engaging in social activity?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

How often do you sleep during the day?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

During the last month have you taken any stimulants (e.g. nicotine, caffeine, amphetamine, decongestants) after 6 pm?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

Are you taking any other medicines? Please list:

………………………………………………………………………………………………

About your sleep medication

How long have you been taking benzodiazepines or “Z” drugs?

2 months or less	2-6 months	6-12 months	1-5 years	More than 5 yrs

During the last month how often have you taken benzodiazepines or “Z” drugs?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

Do you take any additional remedies to help you sleep? (e.g. nytol, herbal remedies, alcohol), please list:

…………………………………………………………………………..

During the last month how often have you taken an additional remedy?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week