

INSTITUTE FOR PERSONAL EXCELLENCE, P.A.

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SLEEP QUESTIONNAIRE

Client Name: _____ DOB: _____

Problems/Symptoms: _____

Medications (name & dosage & when taken): _____

1.	At night, do you fall asleep Immediately Shortly (less than 10 minutes) After some time (about 15-20 minutes) After a long time (up to 1 hour) After a very long time (more than 1 hour)	5 4 3 2 1
2.	Your length of night sleep is: Very long Long Medium Short Very short	5 4 3 2 1
3.	You usually (self) awake through the night Not at all Rarely Not often Often Very often	5 4 3 2 1
4.	Your assessment of your sleep quality is Excellent Good Mediocre (so-so) Bad Awful	5 4 3 2 1
5.	You see dreams _____ while sleeping Not at all Rarely Sometimes Often Provoking anxiety	5 4 3 2 1
6.	The quality of your morning awakening is Excellent Good Mediocre Bad Very Bad	5 4 3 2 1