

Name: _____

Account: _____

Date: _____

Sleep Survey

Using the scale to the right please check the box that most closely corresponds to the questions below.

	Very Frequently	Often	Sometimes	Rarely	Never
I have a consistent sleep routine.					
I work or do other mind-stimulating tasks immediately before turning out the lights.					
My bedroom may be warm or noisy.					
I have trouble staying asleep.					
I take over-the-counter or prescription medication to help me sleep.					
I use alcohol to help me sleep.					
I awake in the morning feeling refreshed and well rested.					
My bed partner may keep me awake by his/her snoring or movements.					
I have difficulty sleeping due to joint or muscle aches and pains.					
If I can't fall asleep easily, I have a relaxing fallback plan.					
I look forward to and enjoy my sleep.					