

Sleep Evaluation

Sleep is a biological need that is vital in maintaining optimal health. Your doctor will review your responses for possible inclusion in your customized treatment plan.

On a typical night in the last month...

1. How many hours of sleep did you get? _____

2. How many minutes does it typically take you to fall asleep? _____

3. Which activities did you do in bed before going to sleep?

(check all that apply)

- Watched TV
- Read a book or magazine
- Listened to music
- Looked at a tablet or smartphone
- None

4. Was your sleep interrupted during the night? For how many minutes in total?

- My sleep was not interrupted
- I was awake for less than 5 minutes
- I was awake for 5-15 minutes
- I was awake for more than 15 minutes

5. Did you wake up in the morning with:

(check all that apply)

- lower back pain
- neck pain
- tingling in your fingers
- headache
- other _____

7. In which position did you sleep most often?

- Stomach Back Side

8. How many pillows did you use to sleep? _____

9. How old is your mattress?

- 1-3 years 4-6 years 7-10 years Over 10 years

10. What type of mattress do you sleep on?

- An innerspring mattress A foam mattress Other _____

11. Do you feel your mattress is comfortable and supportive?

- Yes No Not sure