Sleep Wellness Checklist

Date:

Name:

Address:

City/State/Zip:

Phone: Email:

Rest and Relaxation

Sleep Assessment Questions

Are you able to fall asleep quickly? ( ) yes ( ) no

On average, how many hours do you sleep on work nights? _____

Sleep Quality Questionnaire

Rate from 1-10; 1=never, 10=always

1. When I first awake, I am mentally groggy _____
2. When I get out of bed my muscles feel stiff or sore _____
3. When I get out of bed, I have limited range of motion _____
4. In the afternoon I feel tired, sleepy, or have low energy_____
5. During the day I feel physical and/or mentally stressed ____
6. During the night while sleeping I toss and turn a lot _____
7. During the night I snore or have trouble breathing _____

8. During the night I don’t get all the sleep I require _____

Do you tend to feel too hot or too cold during sleep? ( ) yes ( ) no

Total Sleep Assessment Score _____