Sleep Screening Questionnaire

Which sleep concerns are you experiencing?

☐ Difficulty falling asleep
☐ Frequent awakening during the night
☐ Waking too early
☐ Unrefreshing sleep
☐ Daytime sleepiness
☐ Loud snoring
☐ Waking while choking or gasping
☐ Witnessed pauses in breathing
☐ Morning headaches
☐ Restless or uncomfortable legs
☐ Frequent nighttime urination
☐ Sleep disrupted by pain
☐ Sleep disrupted by hot flashes
☐ Sleep disrupted by anxiety or racing thoughts
☐ Other: _____

How many hours do you usually sleep?

☐ Fewer than five hours
☐ Five to six hours
☐ Six to seven hours
☐ Seven to nine hours
☐ More than nine hours

How much do your sleep problems affect daytime functioning?

☐ Mildly
☐ Moderately
☐ Significantly

What is your primary sleep concern?

_____