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Sleep Disorder Questionnaire

Name:_____
Date:_____

1.How many hours of sleep do you generally get at night?

2. Describe any difficulties you have going to sleep at night.

3. If you wake up during the night, what time is it usually?

4. When you go to sleep, do you have a feeling that you are not safe or secure?

5. Would you say you sometimes struggle with letting go?

6. Do you have disturbing dreams and if yes, in what way?

7. What time do you generally go to sleep?

8. Are there any emotions or (ie. depression or anxiety) that interfere with falling to sleep or that causes you to wake up?

9. Are there any repetitive thoughts that interfere with you falling asleep?

10. How much of any sleep difficulties that you have would you attribute to stress?

11. What do you think would have to happen in order for you to sleep better or stay asleep longer?

12. Have you done any meditational activities or yoga exercises?