

# Current Sleep Status Questionnaire



**Date:** \_\_\_\_\_

***On average over the past **two** weeks:***

**1) How many hours did you sleep each night? \_\_\_\_\_**

**2) How many minutes did it take you to fall asleep?**

- |  |  |
|--|--|
| <input type="checkbox"/> 0-15 minutes  | <input type="checkbox"/> 46-60 minutes |
| <input type="checkbox"/> 16-30 minutes | <input type="checkbox"/> 60 minutes    |
| <input type="checkbox"/> 31-45 minutes |  |

**3) How many times did you wake up each night?**

- |                            |                            |                                      |
|----------------------------|----------------------------|--------------------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 2 | <input type="checkbox"/> 4           |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 3 | <input type="checkbox"/> more than 4 |

**4) How often did you feel rested upon awakening?**

\_\_\_\_\_

0	1	2	3	4	5
Never					Always