PATIENT ASSESSMENT TOOL

SLEEP & ANXIETY QUESTIONNAIRE

PATIENT ASSESSMENT

Your Practitioner would like to find out a bit more about your moods and how well you sleep. Please reflect on how often and/or severely you have experienced the following symptoms over the last 2 weeks. Rate each symptom using this scale:

0 = Never / Not at all
1 = Rarely / Very mildly / 0-1 days per week
2 = Sometimes / Mildly / 2-3 days per week
3 = Often / Moderately / 4-5 days per week
4 = Almost always / Severely / 6-7 days per week

Name: _____

Date: _____

SECTION 1: WORRY & ANXIETY		0	1	2	3	4
1	I feel nervous or anxious					
2	I cannot calm down and feel my thoughts spiralling out of control					
3	I feel restless or fidgety, or cannot sit still					
4	I experience panic and/or anxiety attacks					
5	I have trouble relaxing					
6	I worry about different things					
7	I take pharmaceutical anxiolytic medications to help me relax					
8	I take herbal and/or nutritional anxiolytic medications to help me relax					
9	I become easily annoyed or irritable					
10	I feel afraid that something awful might happen to me or my loved ones					

SECTION 2: GETTING TO SLEEP		0	1	2	3	4
1	I have trouble falling asleep					
2	I drink alcohol to help me get to sleep					
3	I read, watch TV, or do things on my smart phone/digital device for more than 1 hour whilst in bed, before falling asleep					
4	I take pharmaceutical sleeping medications to help me get to sleep					
5	I take herbal and/or nutritional sleeping medications to help me get to sleep					
6	I have restlessness legs and/or cannot keep my legs still when I am trying to get to sleep					
7	I experience a creeping-crawling feeling or tingling in my legs when trying to get to sleep					
8	I experience an inability to move when I am falling asleep or just awakening					
9	I am generally more alert in the afternoons and evenings than in the morning					
10	Thoughts start racing through my mind when I am trying to fall asleep					

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SECTION 3: STAYING ASLEEP		0	1	2	3	4
1	I wake more than 1 time during the night					
2	When I awaken during the night I struggle to get back to sleep					
3	I awaken very early in the morning and cannot get back to sleep					
4	I sleep-walk or move around in my sleep					
5	I have been told I jerk my legs and kick in my sleep					
6	I dream vividly and/or have nightmares					
7	I talk or shout in my sleep					
8	Chronic pain interferes with my sleep					
9	I grind my teeth in my sleep					
10	I have to wake more than 1 time per night to urinate					

SECTION 4: OVERALL QUALITY & QUANTITY OF SLEEP		0	1	2	3	4
1	I awaken feeling unrefreshed or tired					
2	I typically sleep for less than 7 hours per night					
3	I do not go to bed and/or awaken at a regular time every day					
4	I have been told I snore when I sleep and/or I have woken myself up with my snoring					
5	I awaken at night gasping for air and/or stop breathing whilst I sleep					
6	I sweat a great deal at night					
7	I awaken with headaches					
8	I feel drowsy during the day					
9	I take naps during the day					
10	I perform poorly at work due to lack of sleep and/or drowsiness					

PRACTITIONER TO COMPLETE

SECTION	MILD	MODERATE	SEVERE	SCORE	COMMENTS:
Section 1: Worry & anxiety	0 to 12	13 to 23	24 to 40		
Section 2: Getting to sleep	0 to 12	13 to 23	24 to 40		
Section 3: Staying asleep	0 to 12	13 to 23	24 to 40		
Section 4: Overall quality & quantity of sleep	0 to 12	13 to 23	24 to 40		

ADDITIONAL COMMENTS: