

# Sleep Issue Questionnaire

**IF YOU ARE BEING TREATED BY A DOCTOR FOR INSOMNIA, PAIN, OR TAKING ANY PRESCRIPTION MEDICATIONS FOR YOUR SLEEP ISSUE...YOU MUST OBTAIN A REFERRAL FROM YOUR DOCTOR BEFORE BOOKING YOUR INITIAL APPOINTMENT. Our fax # is 603-692-1081.**

**Please print and complete this entire questionnaire (2 pages) and bring it to your initial session. Failure to do so will delay the start of the session and shorten the time we actually spend working together.**

1. Type of issue: (circle)      Going to sleep      Staying asleep      Awakening too early  
Every night or occasionally?
2. Describe what is actually happening. What are you feeling or thinking about?
3. When did this start?
4. What was going on in your life at that time?
5. Are there any childhood or adult traumas that might be keeping you awake? (Be specific)
6. Are you a chronic worrier or do you only suffer when there is a big deadline or crisis pending?
7. What do you worry about?
8. What good comes from being up all night?
9. What is the **DOWNSIDE** to getting rid of this problem?
10. What is the **UPSIDE** to holding onto this problem?
11. Do you feel threatened or unsafe in any way by the thought of letting it go?
12. If there was a deeper emotion underlying this problem, what might it be?
13. If you could live your life over again, what person or event would you prefer to skip?
14. What do you think is causing this sleep Issue?

15. With or after dinner, do you use: caffeine; alcohol; sugar; or nicotine (circle).

Please note...caffeine and sugar are everywhere, read labels to know for sure.

16. Do you get some exercise or physical activity at least 3 times each week?

17. Do you take any medications that could cause sleeplessness?

When in doubt, read labels or discuss with your doctor or pharmacist.

18. Do you have a hobby?                      What?

19. What do you do to relax?

20. What and / or who are the major stressors in your life? (be specific)