

WEEKLY SLEEP QUESTIONNAIRE

DATE: DD MM YYYY

Please circle one response to each of the following questions.

How often during the past week did you :	Not at all	1-2 days	3-5 days	6-7 days
1. Have trouble falling asleep?	0	1	2	3
2. Wake up several times during the night?	0	1	2	3
3. Have trouble staying asleep (woke up earlier than usual)?	0	1	2	3
4. Wake up feeling tired and worn out?	0	1	2	3
5. Feel alert during daytime hours?	0	1	2	3
6. Feel well rested?	0	1	2	3