MADEIRA CHIROPRACTIC AND REHABILITATION
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SLEEP DISTURBANCE QUESTIONNAIRE ❷

Patient Name: _____ Date: _____

Date of Injury: _____

How many hours of sleep do you normally need per night? _____

How many hours of sleep have you been getting per night? _____

Circle the best answer:

Since Your Injury					
Do you have difficulty falling asleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Do you have difficulty staying asleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
If you wake during the night do you have trouble getting back to sleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Do you take anything to help you sleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Does your sleep difficulty affect your ability to function through the day?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Do you have to sleep at different times of the day?	Never	Rarely	Occasionally	Most Days/ Nights	Always

Any other sleep disturbance issues? _____

_____

_____

Patient Signature: _____

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