Stress & Sleep Assessment

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Patient Name: _____ **Date of Birth:** ____/____/____

Today's Date: ____/____/____

STRESS ASSESSMENT

On a scale of 1-10 (1 = minimal stress, 10 = extreme stress), rate your current stress level: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Major sources of stress in your life: (check all that apply) □ Work/career □ Financial □ Relationships □ Family responsibilities □ Health concerns □ Caregiving responsibilities □ Time management □ Major life changes □ Grief/loss □ Other: _____

Please briefly describe your most significant stressors:

_____

_____

How does stress typically affect you? (check all that apply) □ Headaches □ Muscle tension □ Digestive issues □ Sleep disturbances □ Irritability □ Anxiety □ Depression □ Difficulty concentrating □ Changes in appetite □ Changes in energy □ Social withdrawal □ Other: _____

Physical symptoms you experience when stressed:

_____

Emotional patterns you notice when stressed:

_____

How do you currently manage stress? (check all that apply) □ Exercise □ Meditation/mindfulness □ Deep breathing □ Yoga □ Time in nature □ Reading □ Music □ Creative activities □ Socializing □ Professional support (therapy, counseling) □ Spiritual practices □ Medication □ Substance use □ Other: _____

Which stress management techniques have been most effective for you?

_____

Which have been least effective?

_____

STRESS RESPONSE PATTERNS

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When faced with stress, do you tend to: (check all that apply) □ Fight (become angry, argumentative, or confrontational) □ Flight (avoid, escape, or withdraw) □ Freeze (become paralyzed or unable to act) □ Fawn (people-please or put others' needs before your own)

After a stressful event, how long does it typically take you to return to feeling calm? □ Minutes □ Hours □ Days □ Weeks or longer

Do you feel you have adequate resources and support to manage your stress? □ Yes □ No □ Unsure

If no, what additional resources would be helpful?

RESILIENCE ASSESSMENT

On a scale of 1-10 (1 = not at all resilient, 10 = extremely resilient), how would you rate your ability to bounce back from stressful events? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What helps you recover from stress?

SLEEP ASSESSMENT

Average hours of sleep per night: _____

Typical bedtime: _____ **Typical wake time:** _____

Is your sleep schedule consistent (same times each day)? □ Yes □ No

Do you experience difficulty with: (check all that apply) □ Falling asleep □ Staying asleep □ Early morning awakening □ Unrefreshing sleep □ Excessive daytime sleepiness

How long does it typically take you to fall asleep? □ Less than 15 minutes □ 15-30 minutes □ 30-60 minutes □ More than 60 minutes

How many times do you typically wake during the night? _____

If you wake during the night, what typically causes the awakening? □ Need to urinate □ Pain □ Anxiety/racing thoughts □ Noise/environmental factors □ Partner's movements/snoring □ Don't know □ Other: _____

Do you experience any of the following during sleep? (check all that apply) □ Snoring □ Pauses in breathing □ Gasping/choking □ Restless legs □ Sleep talking □ Sleep walking □ Teeth grinding □ Night sweats □ Nightmares □ Sleep paralysis

Has anyone ever told you that you stop breathing during sleep? □ Yes □ No

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Have you ever been diagnosed with a sleep disorder? □ Yes □ No If yes, please specify:

_____

Have you had a sleep study? □ Yes □ No If yes, when and what were the results?

_____

SLEEP ENVIRONMENT

Do you use any sleep aids? (check all that apply) □ Prescription medication: _____ □ Over-the-counter sleep aids: _____ □ Melatonin □ Herbal supplements □ CBD/cannabis products □ Alcohol □ White noise machine □ Earplugs □ Eye mask □ Other: _____

Bedroom environment: (check all that apply) □ Dark □ Quiet □ Cool □ Comfortable bedding □ TV in bedroom □ Electronic devices nearby □ Pets in bed □ Partner with different sleep habits □ Other sleep disruptors: _____

EVENING ROUTINE

Activities in the 2 hours before bed: (check all that apply) □ Work □ Exercise □ Screen time (TV, computer, phone, tablet) □ Reading □ Relaxation practices □ Eating □ Drinking alcohol □ Drinking caffeine □ Other: _____

Do you have a consistent bedtime routine? □ Yes □ No If yes, please describe:

_____

DAYTIME HABITS AFFECTING SLEEP

Caffeine consumption: Type: □ Coffee □ Tea □ Soda □ Energy drinks □ Other: _____ Amount per day: _____ Latest time consumed: _____

Alcohol consumption: Amount per day/week: _____ How close to bedtime?

_____

Napping: □ Do not nap □ Occasional naps □ Regular naps Typical nap length: _____ Time of day: _____

Exercise: □ Morning □ Afternoon □ Evening □ Night Type and duration: _____

Exposure to natural light: How much time do you typically spend outdoors during daylight hours?

_____

SLEEP IMPACT

How does poor sleep affect your daily functioning? (check all that apply) □ Fatigue □ Irritability □ Difficulty concentrating □ Memory problems □ Reduced productivity □ Mood disturbances □ Increased pain □ Reduced immune function □ Other: _____

On a scale of 1-10 (1 = terrible, 10 = excellent), how would you rate your average sleep quality? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

On a scale of 1-10 (1 = not at all, 10 = extremely), how much do sleep issues impact your quality of life? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

SLEEP GOALS

What are your goals related to sleep improvement?

_____

_____

What changes to your sleep habits are you willing to make?

_____

_____

ADDITIONAL INFORMATION

Is there anything else about your stress levels or sleep patterns that you would like to share?

_____

_____

_____

Patient Signature: _____ Date: //____