



Sleep Well Questionnaire

Please circle each question and then add up your score.

1) Do you have difficulty falling asleep?	Yes	No	Sometimes
2) Do you have difficulty staying asleep?	Yes	No	Sometimes
3) Is your sleep unrefreshing or of poor quality?	Yes	No	Sometimes
4) Do you experience excessive sleepiness during the day?	Yes	No	Sometimes
5) Do you 'nap' during the day time	Yes	No	Sometimes
6) Do you sleep less than 5 hours per night?	Yes	No	Sometimes
7) Do you sleep more than 9 hours per night?	Yes	No	Sometimes
8) Do you grind your teeth during sleep?	Yes	No	Sometimes
9) Are you told that you stop breathing whilst you are asleep?	Yes	No	Sometimes
10) Do you gasp, choke or snort during sleep?	Yes	No	Sometimes
11) Do you have unusual dreams or nightmares?	Yes	No	Sometimes

What to do now

If you answered 'Yes' to Do you grind your teeth, please take our 'Unwind your Teeth Grind' questionnaire.

6 or more 'Yes' would indicate the need for a sleep improvement programme. Contact us today for discuss treatment options.