AMERICAN COLLEGE OF
Lifestyle Medicine

LOMA LINDA UNIVERSITY
HEALTH
Produced in collaboration with Loma Linda University

Please complete this form at least one week in advance of your appointment and either:
1) Send through your Patient Portal, or
2) Fax to 910-444-2337

Sleep Assessment

GETTING STARTED

		Very poor health										Excellent health
a.	Please circle your current overall **LEVEL OF HEALTH.**	0	1	2	3	4	5	6	7	8	9	10

b. Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.

Sleep	_______	Weight Management	_______	Nutrition	_______
Exercise	_______	Purpose & Connection	_______	Mental Health	_______
Substance Use	_______				

		Not important at all										Very important
c.	How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
d.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
e.	How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
f.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
g.	How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
h.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10

i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

☐ More medical/scientific knowledge ☐ Practical health tips ☐ Other: ________________

☐ Accountability ☐ Personalized plan

Patient Name:____ DOB: ________________

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SLEEP

Please answer based on your sleeping patterns OVER the LAST TWO WEEKS	Never	Seldom	Sometimes	Often	Always
a. How often have you had difficulty staying awake during routine tasks?	1	2	3	4	5
b. How often have you had difficulty staying awake while driving?	1	2	3	4	5
c. How often have you felt fatigued or needed to nap during the day?	1	2	3	4	5
d. How often has it taken you more than 30 minutes to fall asleep at night?	1	2	3	4	5
e. How often have you woken up at night?	1	2	3	4	5
f. How often have you unintentionally woken up early in the morning?	1	2	3	4	5
g. How often do you look at a screen within 2 hours of sleeping (i.e. TV, computer, iPad, or Phone)?	1	2	3	4	5
h. How often have your legs or arms jerked during sleep?	1	2	3	4	5
i. How often have you experienced “creeping” or “crawling” feelings in your legs?	1	2	3	4	5
j. How often have you snored loudly, gasped, choked, or stopped breathing during sleep?	1	2	3	4	5
k. How often have you used sleeping aids (i.e. tobacco, alcohol, over-the-counter medications, or prescription medications) to help you fall asleep?	1	2	3	4	5
l. Do you have a job that requires night shifts?	1	2	3	4	5
m. Do you have a medical condition or chronic pain that interferes with your sleep?	1	2	3	4	5
n. On an average weekday do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5
o. On an average weekend do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5

Patient Name:____ DOB: __________________

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