Name: _____ Date:_____

Sleep Quality Questionnaire

1. **Have there been any change in your sleep in the last month?**

2. **Have there been any change in your sleep since your last treatment?**

3. **Over the past month, if you could rate the quality of sleep on a scale of 1 to 10, 1 being the worst and 10 being the best, what would you give it?**

4. **How has the quality of sleep changed since your injury?**

5. **How many consecutive hours of sleep have you had per night over the past month?**

6. **How has the number of consecutive hours of sleep per night changed since your injury?**

7. **In total, how many hours a night do you typically sleep?**

8. **Overall, do you feel you sleep better on days you have treatment?**