QUESTIONNAIRE:
SLEEP ASSESSMENT

Metagenics
Genetic Potential Through Nutrition

Patient Name: ______________________ **Age:** ________ **Date:** ______________________

Achieving adequate sleep is fundamental for physical recovery, immune function, mood resilience and cognitive health, amongst many other physiological functions. In order to help your Practitioner thoroughly assess your sleep health, please fill in the following questionnaire.

Note to Practitioners: Refer to the following clinical resources to determine treatment priorities and goals based on questionnaire results: Metagenics Insomnia and Sleep Disruption Protocol and Metagenics Sleep Apnoea protocol.

GENERAL SCREENING	YES	NO
1. Do you struggle to achieve consistent and restful sleep? If yes, how would you describe your sleep issues? ______________________		
2. Have you ever been diagnosed with a sleep disorder? If yes, please provide details: ______________________		
3. Do you suffer from any medical conditions that influence your sleep quality? If yes, please provide details: ______________________		
4. Do you snore loudly or stop breathing during sleep?		
5. Do you use a continuous positive airway pressure (CPAP) machine?		
6. Have you ever performed a sleep study?		
7. Have you ever trialled a cognitive behavioural therapy for insomnia (CBT-I) program involving sleep restriction?		
8. Do you take any medications or supplements (for sleep or other reasons)? If yes, please detail medication/supplement name/brand, dosage and how often you take them: e.g. chemist-bought magnesium supplement, 50 mg, daily.		

Please reflect on your general sleep experience and rate the following areas using a scale of 1 to 5 (1-Very Poor, 2 -Poor, 3-Fair, 4-Good, 5-Very Good).

SLEEP QUALITY	1	2	3	4	5
How refreshed do you feel when you wake up?					
How would you rate your sleep quality?					
Describe your energy levels throughout the day.					

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SLEEP CYCLE INFORMATION

9. When do you usually consume your last food and drink before going to bed? ______________ am/pm

10. Does your meal schedule vary throughout the week? YES NO

11. What time do you usually go to bed? ______________

12. What time do you usually wake up? ______________

13. On the weekend or days off, do you vary your sleep schedule? YES NO

14. How many hours of sleep do you achieve per night? ______________

15. How long does it take you to fall asleep from the time you go to bed? <20 minutes 20-45 minutes 45-60 minutes >60 minutes

16. What do you do while trying to fall asleep (i.e. read, social media, meditation etc.)?

____

17. Do you ever feel 'wired' or anxious at night making it difficult to fall asleep? YES NO

18. Do you wake up in the middle of the night? YES NO

If yes, how often and at what time? ______________

How long has this been an issue? ______________

Are you aware of any reason you might be waking? YES NO

19. Please detail whether any of the following issues **currently** influence your ability to sleep through the night:

Pregnancy
Snoring/restless partner
Hot flushes
Breastfeeding
Disturbing dreams
Pain symptoms
Young children
Pets in the bedroom
Urges to urinate
External traffic noise

20. Do you have trouble falling back asleep when you wake up? YES NO

If yes, how long does it usually take? ______________

21. Does the feeling of restless legs keep you awake? YES NO

22. Do you take naps throughout the day? YES NO

If yes, for how long and at what time? ______________

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SLEEP HYGIENE AND LIFESTYLE REVIEW

23. Are you a shift worker, or work varying shifts as part of your occupation? YES NO

Please outline frequency of night shifts and your typical working roster below:

____

____

____

24. Please indicate and outline the use of the following stimulants:

Item	**Quantity** (i.e. 2 cups daily)	**Frequency** (i.e. daily)	**Timing** (i.e. morning and noon)
Coffee			
Caffeinated drinks			
Green tea			
Black tea			
Chocolate			
Alcohol (outline standard drinks consumed and alcohol type)			
Nicotine (i.e. patches or cigarette smoking)			
Recreational drug use (i.e. cannabis, amphetamines etc.)			

25. How much time do you spend outdoors during the day?

<15 minutes 30-60 minutes 1-3 hours 4-6 hours 7+ hours

26. Does your daily routine involve any kind of continuous bright light exposure (e.g. working in an office/hospital setting)? YES NO

27. Are you exposed to continuous bright light environments within 4 hours of going to sleep? YES NO

28. Do you watch TV/ use electronic devices within 2 to 3 hours of going to bed? YES NO

29. Do you exercise during the evenings? YES NO

If yes, for how long and what time? ______________________________

30. Do you use any physical aids to enhance your sleep quality? YES NO

If yes, outline below (i.e. special pillows, weighted blanket, white noise machine, nasal strips, air filters, other):

____

31. Please indicate whether your bedroom is subject to the following:

External light pollution (i.e. street lamps, sunrise light etc.)

Temperature control (i.e. air conditioning, central heating)

Disruptive noise (i.e. early traffic noise, upstairs neighbours in apartments)

Concentrated electromagnetic field sources (i.e. power box, appliances on opposite side of wall behind bedhead)

32. Has your sleep quality been altered following a significant life event? YES NO

(i.e. change in employment status, marriage, divorce, birth of a child, loss of a loved one, illness in the family, retirement, new relationship, mental health regression etc.)

** Consider screening patient with the Metagenics Mood and Stress Questionnaire if indicated.*

33. Has your residence ever been assessed for environmental mould? YES NO

** Consider screening patient with the Metagenics CIRS and Biotoxins Questionnaire and visual contrast sensitivity (VCS) testing if presenting with fatigue, aches and other symptoms of biotoxin issue.*

MET-D1310 - 08/20