Women's Sleep Health Intake Questionnaire

Personal Information

Name

Age

Email

Phone

Occupation

Sleep Patterns

Typical Bedtime (Weekday)

Typical Wake Time (Weekday)

Typical Bedtime (Weekend)

Typical Wake Time (Weekend)

Average hours of sleep per night

Sleep Issues

Are you experiencing any of the following?

- Trouble falling asleep
- Trouble staying asleep
- Frequent awakenings
- Early morning awakening
- Nightmares
- Restless legs
- Snoring
- Pauses in breathing
- None

Other sleep issues

Daytime Functioning

Daytime Functioning

Do you experience any of the following during the day?

Fatigue
Difficulty concentrating
Mood changes
Morning headaches
None

Medical & Lifestyle Factors

Relevant medical conditions (e.g. pregnancy, PCOS, menopause, chronic pain, anxiety, depression, etc.)

Current medications, supplements, or sleep aids

Daily caffeine consumption (type and amount)

Alcohol consumption (frequency and amount)

Tobacco/nicotine use (form and frequency)

Exercise (type, frequency, time of day)

Additional Notes or Concerns