Teen SleepHealth Inventory

Sleep is an important component of your health, safety, productivity and wellbeing. In order to build a healthy lifestyle, it is essential that you practice good sleep and health habits. This questionnaire will help you record some of your current habits and relevant experiences. It will also provide information about areas you can improve upon to address any sleep or alertness problems that you may be experiencing. If you are having sleep or alertness problems, share this sheet with your doctor or other healthcare provider and discuss your issues. Please select the answer that best describes your sleep/wake behavior:

1.	What time do you usually wake up during the weel	k?	О	n the weekend?					
2.	What time do you usually go to sleep during the w	eek?	O	n the weekend?					
3.	On a typical weekday, how many hours, not include a) 4-5 hrs b) 5-6 hrs c) 6-7 hrs d) 7-8 hrs	ling naps, do e) 8-9 hrs							
4.	On a typical weekend or non-workday, how many I a) 4-5 hrs b) 5-6 hrs c) 6-7 hrs d) 7-8 hrs e			g naps, do you usually sl nan 9 hrs	eep				
5.	On average, how often do you take a nap? a) Every or almost every day b) A few days/week c) A few days/month d) Rarely/Never								
6.	On most nights, how would you rate the quality of your sleep? a) Poor b) Fair c) Very good e) Excellent								
7.	On an average day, when do you typically exercise? a) Morning b) Afternoon c) A couple hours before bed d) Never								
8.	How many caffeinated drinks (12 oz.) do you consua) 0 b) 1-2 c) 3-4 d) 5-6 e) More than 6	ume on an av	erage	day					
9.	Do you think you have a sleep problem? a) Yes b) No c) Maybe								
10.	 Check if any of the following apply to you: Snore loudly You or others have observed that you stop breathing or gasp for breath during sleep Feel sleepy or doze off while watching TV, reading, driving or engaged in daily activities Have difficulty sleeping 3 nights a week or more (e.g., trouble falling asleep, wake frequently during the night, wake too early and cannot get back to sleep or wake unrefreshed) Feel unpleasant, tingling, creeping feelings or nervousness in your legs when trying to sleep Interruptions to your sleep (e.g., nighttime heartburn, bad dreams, pain, discomfort, noise, sleep difficulties of family members, light or temperature) 								
11.	. How often do any of the following disrupt your sleep? a) Every or almost every night b) A few nights/week c) A few nights/month d) Rarely/Never								
	Pain or physical discomfort Allergies or respiratory problems Nasal congestion Indigestion and/or heartburn Stress or worries Noise, light or temperature Snoring of a family member Feeling uncomfortable due to bedding or pillow	a a a a a a	b	d d d d					

12.	How frequently do you use t a) Every or almost every day	he following sleep aid b) A few days/week	ds to help you sleep? c) A few days/month	d) Rarely/Never					
	Over-Over-the-counter or store-by Medication prescribed by a doctor		a b c d a b c d						
13.	How often is it difficult to w a) Every or almost every day	ake up on school days b) A few days/week	s? c) A few days/month	d) Rarely/Never					
14.	How often do you feel so tire a) Every or almost every day	ed or sleepy that it in b) A few days/week	terferes with your sch c) A few days/month	nool activities? d)Rarely/Never					
15.	15. In the past 7 days								
	I had a problem with my sleep Not as all a little bi		Quite a bit Very n	nuch					
	I got tired easily Not as all a little bi	t Somewhat	Quite a bit Very n	nuch					
	I had a hard time getting thing Not as all a little bi		epy Quite a bit Very n	nuch					
	I felt alert when I woke up Not as all a little bi	t Somewhat	Quite a bit Very n	nuch					
	I had problems during the day Not as all a little bi		Quite a bit Very n	nuch					
	I had a hard time concentratin Not as all a little bi		Quite a bit Very n	nuch					
	I was sleepy during the daytim Not as all a little bi		Quite a bit Very n	nuch					
	I had trouble staying awake du Not as all a little bi	= -	Quite a bit Very n	nuch					
	l often felt tired? Never Rarely	Sometimes	Often Always	S					
	How often did your fatigue limit you at school (include homework at home)? Never Rarely Sometimes Often Always								
	How often were you too tired Never Rarely	to think clearly? Sometimes	Often Always	S					
	How often did you have enoug Never Rarely	h energy to exercise str Sometimes	enuously? Often Always	S					
16.	Have you ever had an accident at work or at home that you thought was, at least partially caused by being tired? a) Yes b) No								
17.	How often do you drive drow a) Every or almost every day	vsy? b) A few days/week	c) A few days/month	d) Rarely/Never					
18.	How often have you dozed o a) Every or almost every day		oment, while at the w c) A few days/month	wheel of a vehicle? d) Rarely/Never					