

Name: _____

Date: _____

Sleep Problems Scale

Please answer the following questions about your sleep in the past 3 months. If possible, ask your sleep partner to complete another copy of the scale about your sleep problems.

	No Problem	Mild Problem	Moderate Problem	Severe Problem
Difficulty falling asleep				
Difficulty staying asleep				
Waking up too early				
Feeling refreshed in the morning				
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Crawling or aching feelings in legs during sleep				
Not able to keep legs still during sleep				
Leg twitches or jerks during sleep				
Leg cramps upon awakening				
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Loud snoring during sleep				
Gaspings for air during sleep				
Choking during sleep				
Whole body movements during sleep				
Headaches upon awakening				
Bluish skin or lips upon awakening				
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Nodding off or falling asleep while reading				
Nodding off or falling asleep while watching TV				
Nodding off or falling asleep while eating				
Nodding off or falling asleep while driving				
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Sudden sleep attacks				
Paralyzed upon awakening				
Vivid dreams or hallucinations when falling asleep				
Periods of sudden muscle weakness while awake				
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Sour taste in mouth upon awakening				
Heartburn during sleep or upon awakening				
Regurgitating during sleep or upon awakening				
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Nightmares				
Sleep-walking				
Grinding teeth				

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