Specialty Behavorial Health
www.sbh-sd.com

Name:_____ Date:_____

Information About Sleep Aids

Information About **Current Use** (in past 30 days) of Sleep Aids

Current **prescribed medications** to help sleep. Check here if none: _____

Medication	Dose	How often I use	Prescribed by:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current **over-the-counter medications** to help sleep. Check here if none: _____

Medication	Dose	How often I use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Herbal or homeopathic remedies to help sleep. Check here if none: _____

Remedy	Dose	How often I use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other current sleep aids: _____

Information About **Past Use** of Sleep Aids

Please list all information about any sleep aids you have used in the past.

Sleeping Aid	Dates Used	Helpfulness 0 = none 5 = very helpful	Any problems or side-effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____