WELLBEING CHIROPRACTIC

Bed and Sleep Assessment Form

Patient Name:_____ **Date**:_____

How old is your current mattress?_____
How old is your current pillow?_____
Where did you get your current mattress from?_____

What describes your current mattress? (Select all applicable)

‡ Extra Firm ‡ Firm ‡ Intermediate ‡ Soft
‡ Latex ‡ Spring‡ Foam ‡ Water ‡ Viscoelastic ‡ Other

What do you like about your current mattress? _____

What don't you like about your current mattress?_____

Approximately how much do you weigh?_____

In what position do you sleep? ‡ Side ‡ Stomach ‡ Back ‡ Combination

Do you experience any of the following?

1. *Sleeping with your hand under your pillow?*
   ‡ Never ‡ Seldom ‡ Usually ‡ Always
2. *Broken sleep*
   ‡ Never ‡ Seldom ‡ Usually ‡ Always
3. *Waking up with stiffness/soreness in any of the following areas?*
   ‡ Neck ‡ Mid-back ‡ Low back ‡ Shoulders ‡ Knees
   ‡ Other _____
4. *Waking up with numbness, pins and needles? If so, where* _____
   ‡ Never ‡ Seldom ‡ Usually ‡ Always
5. *Trouble falling asleep*
   ‡ Never ‡ Seldom ‡ Usually ‡ Always
6. *Constant tossing and turning*
   ‡ Never ‡ Seldom ‡ Usually ‡ Always
7. *Sleep apnea*
   ‡ No ‡ Yes

How would you rate the quality of your sleep?

‡ Excellent ‡ Good ‡ Average ‡ Poor

Do you feel refreshed and rested when you wake up?

‡ Never ‡ Seldom ‡ Usually ‡ Always

How often is your sleep disturbed by your partners movement?

‡ Never ‡ Seldom ‡ Usually ‡ Always ‡ N/A