INSOMNIA - 6 POINT ASSESSMENT CHECK LIST				
	6 POINTS	**On scale of 1 to 10 , please rate the items below:** **Not what I want** **Just what I want** **1 2 3 4 5 6 7 8 9 10**	**WHAT I'D LIKE TO CHANGE, And can change on my own:**	**WHAT I'D LIKE TO CHANGE, And need help or more information to do so:**
1	**Sleep hygiene**: Bedtime ritual/routine, how well do you trigger your body for sleep before bed?	* Consistent time to bed **1 2 3 4 5 6 7 8 9 10** * Bedtime routine **1 2 3 4 5 6 7 8 9 10** (to signal to body it's time to sleep)		
2	**Sleep environment**: Is my sleep area comfy and to my liking?	* Mattress **1 2 3 4 5 6 7 8 9 10** * Pillow **1 2 3 4 5 6 7 8 9 10** * Lighting in room **1 2 3 4 5 6 7 8 9 10** * Noise in the room **1 2 3 4 5 6 7 8 9 10** * Allergies **1 2 3 4 5 6 7 8 9 10** (mattress/pillow encasings if needed, flooring, bedding washed weekly in hot water) * Pets sleeping where you want them **1 2 3 4 5 6 7 8 9 10** * Anything impacting sleep environment? **1 2 3 4 5 6 7 8 9 10**		
3	**Diet**: (what and when you eat)	* Caffeine consumption **1 2 3 4 5 6 7 8 9 10** * Heavy meals **1 2 3 4 5 6 7 8 9 10** * Sugar/ junk food **1 2 3 4 5 6 7 8 9 10** * Nicotine **1 2 3 4 5 6 7 8 9 10** * Alcohol **1 2 3 4 5 6 7 8 9 10** * Recreational drugs **1 2 3 4 5 6 7 8 9 10**		
4	**Daily Physical Activity**	* Physical activity **1 2 3 4 5 6 7 8 9 10**		

	6 POINTS	On a scale of 1 to 10, please rate the items below: almost always 1 2 3 4 5 6 7 8 9 10 almost never	WHAT I'D LIKE TO CHANGE, And can change on my own:	WHAT I'D LIKE TO CHANGE, And need help or more information to do so:
5	**Stress, mood and invasive thoughts**:	* I am comfortable with how I manage stress in my life **1 2 3 4 5 6 7 8 9 10** * I feel as if I have no control over my schedule and/or to do list **1 2 3 4 5 6 7 8 9 10** * I feel supported and understood **1 2 3 4 5 6 7 8 9 10** *Thoughts of worry or fear keep me awake at night **1 2 3 4 5 6 7 8 9 10** **Please answer YES (Y), NO (N) or Not Applicable (N/A) to the following**: * I would like to learn more about relaxation activities to help my body relax **Y N** * I have been diagnosed with depression **Y N** *My depression is being adequately treated **Y N N/A** *I have not been diagnosed with depression, but have feelings of hopelessness, trouble sleeping and have lost interest in hobbies **Y N** *I feel angry every day **Y N** *I have experienced a significant loss or trauma **Y N**		
6	**Medical Issues:**	**Please answer YES (Y) or NO (N) to the following:** * I have a medical issue impacting sleep **Y N** * This is being managed to my satisfaction **Y N** * I think I might have a medical issue impacting sleep **Y N** * I would like to f/u with my doctor about this **Y N** * I am taking medications I believe are impacting my sleep negatively **Y N** * I would like to f/u with my doctor about this **Y N**		

Sponsored by:

Anna C. DeLong, MSW, LCSW
UVA Faculty and Employee Assistance Program
434) 243-2643
www.uvafeap.com