This form is to be completed by the patient:

**PAIN AND SLEEP QUESTIONNAIRE 3 QUESTION**

Thinking back over the last week, how has pain affected your sleep? For each of the following questions, place a slash (/) through the line at the point you feel applies to you.

1. How often have you had trouble falling asleep because of pain?
   - NEVER
   - ALWAYS

2. How often have you been awakened by pain during the night?
   - NEVER
   - ALWAYS

3. How often have you been awakened by pain in the morning?
   - NEVER
   - ALWAYS