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 your 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