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### Chronic Pain Centre

**Sleep Group Summary**

**Leader:** \_\_\_\_\_\_\_\_\_\_\_ **Start Date**: \_\_\_\_\_\_\_\_\_\_\_\_ **End Date**: \_\_\_\_\_\_\_\_\_\_\_\_ **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Program?** **NMSK**  O **Headache** O **Pelvic** O

|  |  |  |
| --- | --- | --- |
| **sleep pattern**  | **Before** **(Session 2)** | After (Session 4) |
| 1. How many **minutes** does it take you to fall asleep? (average over past week)
 |  |  |
| 2. How many **times** do you awaken in the night? (average over past week) |  |  |
| 3. How many **hours** of sleep do you get per night? (average over past week)  |  |  |
| 4. What is your sleep efficiency (**percentage**)? (average over past week) |  |  |

What sleep strategies have you implemented over the past **4** weeks?

Leader Impressions: The client attended \_\_\_/4 sessions

Leader Recommendations:

Group Facilitator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature