Let's Yarn About SLEEP!

Sleep Health Assessment

Name: _____ **Date:** _____

Notes for the respondent

This activity aims to screen how well you sleep, what affects your sleep and how sleep affects you. Please answer the questions about yourself and your sleep concerning the most recent typical week. There is no right or wrong answer.

Notes for the survey administrator

Sections A and B are not focused on sleep health issues but provide meaningful contextual information for holistic assessment of sleep health issues. Section C covers items on sleep health issues. Section D covers factors affecting sleep health or contributing to the risk of poor sleep. Section E assesses participants' understanding of sleep health needs and impacts.

SECTION A

Q.No	Can we ask some questions to know more about you and your mob? **Please write your answers in the given space. For multiple-choice questions, please select the most appropriate response.**				
1	Age	_____ years			
2	Gender	☐ Male	☐ Female	☐ I prefer not to say	
3	Do you identitfy as	☐ Aboriginal	☐ Torres Strait Islander	☐ Aboriginal and Torres Strait Islander	☐ Non-Indigenous
4	Your Traditional group (Mob)	_____			
5	The language you speak at home	_____			

SECTION B

Q.No	Can you tell us where you live (your house and neighbourhood)? Please write your answers in the given space. For multiple-choice questions, please select the most appropriate response.					
1	Who do you live with?					
2	How many people live in your house?					
3	How many bedrooms are in your house?					
4	Do you have a bedroom of your own?	☐ Yes	☐ No			
5	If no, then how many people do you share the bedroom with?					
6	Is there a safe sleeping space available to you every time you sleep?	☐ Yes	☐ No	☐ Not always		
7	Is there a clean sleeping space available to you every time you sleep?	☐ Yes	☐ No	☐ Not always		
8	Your neighbourhood is (you can select multiple options)	☐ Quiet	☐ Safe	☐ Noisy	☐ Violent	☐ Others

SECTION C

Q.No	Can we ask some questions about your sleep routine and sleep problems? **Please write your answers in the given space. For multiple-choice questions, please select the most appropriate response.**				
1	When do you usually go to sleep?	Weekdays: _____	Weekend: _____		
2	When do you usually wake up?	Weekdays: _____	Weekend: _____		
3	How long does it take you to fall asleep?	☐ 15 minutes or less	☐ 15–30 minutes	☐ 30–60 minutes	☐ More than 1 hour
4	On average, how many times do you wake up in the middle of your sleep?	_____			
5	What wakes you up?	_____			
6	Do you take naps/short sleep during the day?	☐ Yes	☐ No		
7	If yes, then what is the duration of your nap?	☐ 15–30 minutes	☐ 30–60 minutes	☐ More than 1 hour	
8	Do you think the number of hours you sleep is	☐ Barely enough	☐ Enough	☐ More than enough	
9	In the morning, you wake up	☐ By yourself	☐ Someone else wakes you up		☐ Alarm
10	How long does it take you to get out of bed after your alarm goes off or someone wakes you up? Please answer in minutes.	_____ minutes			
11	Overall, your sleep is	☐ Great	☐ OK	☐ Poor	

SECTION C (continued)

12	Over the past two (2) weeks, have you experienced difficulty falling asleep?	☐ Never	☐ Sometimes	☐ Often
13	Over the past two (2) weeks, have you experienced difficulty staying asleep?	☐ Never	☐ Sometimes	☐ Often
14	Over the past two (2) weeks, have you experienced feeling tired upon waking?	☐ Never	☐ Sometimes	☐ Often
15	Over the past two (2) weeks, have you experienced daytime sleepiness?	☐ Never	☐ Sometimes	☐ Often
16	Have you seen anyone for your sleep problems? (Please don't answer if you don't think you have any sleep issues)	☐ Yes	☐ No	
17	Have you ever been told that you make repeated leg or arm jerking movements during sleep?	☐ Yes	☐ No	
18	Have you ever been told that you snore loudly at night?	☐ Yes	☐ No	
19	Do you think your sleep problems are interfering with your daily functioning?	☐ Not at all	☐ Somewhat	☐ A lot
20	How worried are you about your sleep?	☐ Not at all	☐ Somewhat worried	☐ Very much worried
21	In the past 12 months, has anyone asked how your sleep is?	☐ Yes	☐ No	
22	If yes, please share who that was (friend, family, teacher, doctor, someone at work)			
23	How do you feel when you don't get enough sleep?			
24	How do you feel when you sleep well?			

SECTION D

Q.No	You are doing great! Can we talk about the factors that might affect your sleep **Please write your answers in the given space. For multiple-choice questions, please select the most appropriate response.**				
1	Do you have any health problems diagnosed by a doctor?	☐ Yes	☐ No		
2	If yes, what is it?				
3	How is your health in general?	☐ Good	☐ Ok	☐ Poor	
4	How many times a week did you go to sleep hungry?	☐ Less than once	☐ 1–2 times	☐ 3 or more times	
5	Is anything in your life or has happened in the past that is affecting your sleep? (You may select more than one option).	☐ Death of a family member ☐ Family breakdown ☐ Housing issues ☐ Racism ☐ Bullying ☐ Domestic violence ☐ Money problems at home ☐ Living away from family		☐ Your trouble with the police/court ☐ Parents' trouble with police/court ☐ Neighbourhood crime/violence ☐ Neighbourhood noise ☐ Problems at school ☐ Childhood experience/trauma ☐ Other issues ☐ None	
6	How many hours do you spend on screen time, including watching TV, using phones, and playing video games?	☐ Less than 1 hour	☐ 1–2 hours	☐ 2–4 hours	☐ More than 4 hours
7	Do you smoke cigarettes?	☐ No, I don't smoke	☐ Everyday	☐ Sometimes (1–2 times a week)	☐ Rarely (once a month)

SECTION D (continued)

8	Do you drink alcohol?	☐ No, I don't drink alcohol	☐ Everyday	☐ Sometimes (1–2 times a week)	☐ Rarely (once a month)
9	Do you take drugs?	☐ No, I don't take drugs	☐ Everyday	☐ Sometimes (1–2 times a week)	☐ Rarely (once a month)
10	How many times in a week do you spend at least 20 minutes on physical activity (running, walking, gymnastics, swimming)	☐ I don't exercise	☐ Less than once	☐ 1–3 times	☐ More than 3 times
11	Does your homework or school assignments affect your sleep?	☐ Yes	☐ No	☐ Sometimes	

SECTION E

Q.No — **We are nearly done! Can we know more about your understanding of sleep health?**

Please write your answers in the given space. For multiple-choice questions, please select the most appropriate response.

1	What is the recommended sleep duration for someone your age?			
2	Do you know what happens when you sleep	☐ None at all	☐ Some understanding	☐ Good understanding
3	Do you know about healthy sleep habits?	☐ None at all	☐ Some understanding	☐ Good understanding
4	Do you know how poor sleep affects your mind, body and soul in the short term?	☐ None at all	☐ Some understanding	☐ Good understanding
5	Do you know how poor sleep affects your mind, body and soul in the long term?	☐ None at all	☐ Some understanding	☐ Good understanding

SECTION E (continued)				
6	Do you think sleeping in on weekends can help you recover from short sleep during the week?	☐ Yes	☐ No	☐ Maybe
7	Do you know how you can improve your sleep?	☐ No	☐ Some understanding	☐ Good understanding

This is the end of the questionnaire.

Suggested citation: Let's Yarn About Sleep-Sleep Health Assessment Tool for First Nations Peoples in Australia (2024). The University of Queensland, Brisbane.

This tool was co-designed with the Mount Isa (Kalkadoon Country) community in Queensland. We acknowledge the Traditional Custodians and Knowledge Holders of the lands where this tool was conceived and developed. We extend our respect and gratitude to the past, present, and emerging leaders and Elders who have guided every stage of the Let's Yarn About Sleep program.

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