SLEEP & PTSD / BEFORE YOUR VISIT

Your nights deserve a clearer conversation.

A practical guide to describing persistent sleep difficulty, asking about care and checking what happens next.

Start with your experience

You may be exhausted and still feel on guard at bedtime. Sleep problems can be part of PTSD and may need focused attention even when other symptoms improve. A post cannot tell you what is causing your sleep difficulty.

Use this guide with the care team you have

Bring your actual pattern and one example of its effect on your day. Your clinician determines the diagnosis and treatment. No benefits status, purchase or predetermined finding is required.

What is inside

Describe the pattern. Bring the treatment history. Ask about sleep-focused care. Leave with a clear next step. This is health education, not a diagnosis or a rating guide.

01 / DESCRIBE YOUR NIGHTS

Give the pattern. Show the impact.

A short sleep diary can help you remember the details. NIH suggests that one to two weeks may be useful before a visit; do not delay care to complete a diary.

Record what you can

Note bedtime, approximate time to fall asleep, nighttime waking and morning wake time. Include naps and daytime sleepiness. Say when you are estimating; exact minute-by-minute accuracy is not the goal.

Explain what it changes

Choose a real example from work or home. Perhaps you reread the same paragraph or needed to postpone an activity. Use only examples that actually happened, and explain how often.

Mention other observations

Tell your clinician about nightmares if present. If you or a partner notice loud snoring, gasping or breathing pauses, report those observations too. They are clues for assessment, not proof of a diagnosis.

02 / BRING THE TREATMENT STORY

What have you tried? What is still happening?

Your sleep history includes more than bedtime. A current list helps your clinician understand the whole picture.

Bring names and actual use

List prescription and over-the-counter medicines, supplements and sleep aids, with the timing you actually use. Include caffeine, nicotine, alcohol or other substances honestly. Do not change or stop treatment for this appointment.

Describe the response

Explain what helped, what did not and any effects that concern you. If PTSD care is helping but sleep has not improved, say so. That observation is useful without deciding the cause yourself.

Use records you already have

Bring relevant visit notes or previous sleep-test reports if available. Ask whether further evaluation is needed. Do not assume a sleep study is required for every sleep complaint.

03 / ASK ABOUT FOCUSED CARE

Give sleep its own place in the visit.

For chronic insomnia, the 2025 VA/DoD guideline recommends cognitive behavioral therapy for insomnia, or CBT-I. It is structured treatment, beyond a list of basic bedtime tips.

A useful opening

Illustrative language, only if true: “My sleep is still disrupting my day. Could we assess the sleep problem itself and discuss whether CBT-I would help?”

Ask what needs evaluating

“What might be contributing to this pattern?” “Do the breathing changes or nightmares I described need further evaluation?” Your clinician decides which findings, tests or referrals are appropriate.

Ask how care would work

“How can I access CBT-I if it is appropriate?” “What should I track, and when should we follow up?” This guide does not provide a self-directed sleep-restriction plan or tell you to change medication.

04 / FOLLOW UP WITH A CLEAR RECORD

Leave knowing the next step.

Before the visit ends, repeat the plan back in your own words. Ask who will arrange any referral and how to get help with questions between visits.

Check the factual record

When the visit note is available, check that your symptom history, medicines and reported daily impact are accurate. If a factual detail is wrong, contact the care team and explain the specific correction. A clinician's assessment may differ from your interpretation.

Keep the purpose clear

You describe your experience. Clinicians establish findings. This guide does not establish individual causation, secondary service connection or a separate disability rating.

Sources and reading

VA National Center for PTSD: Sleep Problems in Veterans with PTSD; Sleep Problems and PTSD. VA/DoD 2025 Insomnia/OSA guideline, recommendations 5, 7 and 8. NIH/NHLBI: Insomnia - Diagnosis (updated March 24, 2022). All accessed September 20, 2026.

Sleep Problems in Veterans with PTSD

Sleep Problems and PTSD

VA/DoD Insomnia/OSA Clinical Practice Guideline

NHLBI Insomnia - Diagnosis

CONTROL THE FOUNDATION

Your health is where the evidence begins.

You cannot control the VA, the examiner or the timeline. You can take the next step toward having your conditions properly evaluated and your daily reality accurately documented.

Four paths. Only one brings both pieces together.

Wrong medicine. Wrong claim.

Gaps in the medical foundation and the claims process.

Wrong medicine. Right claim.

The right filing cannot fill gaps in the medical record.

Right medicine. Wrong claim.

The medical foundation is there, but is not put to work correctly.

Right medicine. Right claim.

Health evaluated. Findings documented. Evidence put to work.

Leave either piece incomplete and you risk a denial or a rating that does not reflect the conditions you live with. Start with your health. It is the foundation the claim depends on.

You can start with your care team. Or let us coordinate it.

VHN brings veteran-focused independent care, records, appointments and follow-up into one coordinated process. Your case manager keeps the moving pieces connected. Use your own accredited representative, or ask about an introduction.

SEE IF VHN IS RIGHT FOR YOU

Independent clinicians establish medical findings. Accredited representatives handle claims. The VA decides outcomes.