

Sleep Diary



Complete in the Morning

Start Date: _/_/	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day of the week: _____	_____	_____	_____	_____	_____	_____	_____
I went to bed last night at:	: PM/AM	: PM/AM	: PM/AM	: PM/AM	: PM/AM	: PM/AM	: PM/AM
I got out of bed this morning at:	: PM/AM	: PM/AM	: PM/AM	: PM/AM	: PM/AM	: PM/AM	: PM/AM
Last night I fell asleep:							
Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After some time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I woke up during the night:							
# of Times							
# of Minutes							
Last night I slept total of:	Hours	Hours	Hours	Hours	Hours	Hours	Hours
My Sleep was Disturbed by: List mental or physical factors including noise, lights, pets, allergies, temperature, discomfort, stress, etc.							
When I woke up for the day, I felt:							
Refreshed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat refreshed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes: Record any other factors that may affect your sleep (hours of work shift, or monthly cycle for women).							

Sleep Diary



Complete in the Evening

Day of Week:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
I consumed caffeinated drinks in the (M)orning, (A)fternoon, (E)vening, (N/A)							
M/ A/ E/ NA	M _____ A _____ E _____	M _____ A _____ E _____	M _____ A _____ E _____	M _____ A _____ E _____	M _____ A _____ E _____	M _____ A _____ E _____	M _____ A _____ E _____
How many?							
I exercised at least 20 minutes in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
	M A E	M A E	M A E	M A E	M A E	M A E	M A E
Medications I took today:							
Took a Nap? (Circle one)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If yes, for how long?							
Throughout the day, my mood was... Very pleasant, Pleasant, Unpleasant, Very unpleasant							
Approximately 2-3 hours before going to bed, I consumed:							
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A heavy meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the hour before going to sleep, my bedtime routine included: (list activities including reading, using electronics, taking a bath, relaxation exercises, etc.)							