

Sleep Diary

The quality and quantity of our sleep greatly affects our physical health, brain function and well-being. Yet so many people struggle with getting a good night's sleep! The first step in addressing a sleep problem is to find out what is causing it. Start by keeping a diary of your sleep habits for a least seven days to see if you can uncover any patterns. Could your daily or nightly habits be contributing to the problem? Are there simple changes you could make to improve your sleep? If your sleep problem continues or gets worse, share this diary with your medical provider and ask for a sleep assessment.

COMPLETE IN THE MORNING

Date							
Time I went to bed last night:							
Time I got out of bed this morning:							
I fell asleep last night:							
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:							
Number of times							
Number of minutes							
Total number of hours I slept last night:							
My sleep was disturbed by: stress, discomfort, noise, lights, pets, allergies, temperature, 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"/>



COMPLETE IN THE EVENING

Date							
Number of caffeinated drinks I consumed in the:							
Morning							
Afternoon							
Evening							
Days I exercised for at least 20 minutes:							
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications I took today:							
Before Noon							
Before Bed							
Number of minutes I napped:							
During the day, how likely was I to doze off while performing daily activities:							
None, Slight, Moderate, High							
Today my mood was:							
Very pleasant, Pleasant, Unpleasant, Very unpleasant							
Approximately 2-3 hours before 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"/>
In the hour before going to sleep, my bedtime routine included:							
Reading, using electronics, bath, relaxation exercises, etc.							

