**Daily Sleep Diary**

**Complete the diary every day in the morning when you wake up and at the end of the day before you go to sleep.**

**The sleep diary only takes a few minutes each day to complete. Make small changes. Changing one habit at a time can set you on the path to a healthy sleep.**

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| **Complete in the Morning** |
|  | **Day 1****Day of the week\_\_\_\_\_\_** | **Day 2****Day of the week\_\_\_\_\_\_** | **Day 3****Day of the week\_\_\_\_\_\_** | **Day 4****Day of the week\_\_\_\_\_\_** | **Day 5** **Day of the week\_\_\_\_\_\_** | **Day 6****Day of the week\_\_\_\_\_\_** | **Day 7****Day of the week\_\_\_\_\_\_** |
| What time did you go to bed last night? |  |  |  |  |  |  |  |
| Did you fall asleep:**Easily****After some time****With difficulty** |  |  |  |  |  |  |  |
| After falling asleep, how many times did you wake up in the night? |  |  |  |  |  |  |  |
| How many hours total did you sleep last night? |  |  |  |  |  |  |  |
| What time did you **wake** up this morning? |  |  |  |  |  |  |  |
| What time did you **get out of bed** this morning? |  |  |  |  |  |  |  |
| When you woke up, did you feel: **Refreshed & Rested****Somewhat rested****Fatigued** |  |  |  |  |  |  |  |
| **Complete at the End of Day** |
|  | **Day 1****Day of the week\_\_\_\_\_\_** | **Day 2****Day of the week\_\_\_\_\_\_** | **Day 3****Day of the week\_\_\_\_\_\_** | **Day 4****Day of the week\_\_\_\_\_\_** | **Day 5** **Day of the week\_\_\_\_\_\_** | **Day 6****Day of the week\_\_\_\_\_\_** | **Day 7****Day of the week\_\_\_\_\_\_** |
| What medications did you take today? |  |  |  |  |  |  |  |
| How much caffeine did you drink today? |  |  |  |  |  |  |  |
| How much alcohol did you drink today? |  |  |  |  |  |  |  |
| How many minutes of exercise today? |  |  |  |  |  |  |  |
| Did you take a nap today? Yes/NoHow long? | * Yes
* No

Time: \_\_\_\_\_\_ | * Yes
* No

­­­Time: \_\_\_\_\_\_ | * Yes
* No

­­­Time: \_\_\_\_\_\_ | * Yes
* No

­­­Time: \_\_\_\_\_\_ | * Yes
* No

­­­Time: \_\_\_\_\_\_ | * Yes
* No

­­­Time: \_\_\_\_\_\_ | * Yes
* No

­­­Time: \_\_\_\_\_\_ |
| In the hour before going to sleep, what did your bedtime routine look like:(i.e., read a book, used electronics, watched TV, took a bath, relaxation exercise, etc. |  |  |  |  |  |  |  |