



# Sleep Diary

Please fill out page 1 and 2 each day.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Starting Date: \_\_\_\_\_ End Date: \_\_\_\_\_

## ANSWER IN THE MORNING AFTER WAKING FOR THE DAY

	At what time did you first go to bed last night?	Approximately how long did it take you to fall asleep?	About how many times if any did you awaken during the night?	Overall, about how many hours did you sleep?	At what time did you wake up (for the last time) this morning?	In general, how did you feel when you woke up?
DAY 1						<input type="checkbox"/> Very Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigued
DAY 2						<input type="checkbox"/> Very Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigued
DAY 3						<input type="checkbox"/> Very Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigued
DAY 4						<input type="checkbox"/> Very Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigued
DAY 5						<input type="checkbox"/> Very Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigued
DAY 6						<input type="checkbox"/> Very Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigued
DAY 7						<input type="checkbox"/> Very Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigued

# Sleep Diary

ANSWER AT BEDTIME JUST BEFORE YOU GO TO SLEEP			
	How much time, if any, did you spend napping during the day?	Did you consume any of these substances during the day?	On a scale of one to five, how would you rate your overall mood and overall functioning during the day?
DAY 1		<input type="checkbox"/> Caffeine (within 6 hours of bedtime) <input type="checkbox"/> Alcohol (within 1 hour of bedtime) <input type="checkbox"/> Medication (type: _____ )	<input type="checkbox"/> 5 – Positive & Energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – Depressed & Lethargic
DAY 2		<input type="checkbox"/> Caffeine (within 6 hours of bedtime) <input type="checkbox"/> Alcohol (within 1 hour of bedtime) <input type="checkbox"/> Medication (type: _____ )	<input type="checkbox"/> 5 – Positive & Energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – Depressed & Lethargic
DAY 3		<input type="checkbox"/> Caffeine (within 6 hours of bedtime) <input type="checkbox"/> Alcohol (within 1 hour of bedtime) <input type="checkbox"/> Medication (type: _____ )	<input type="checkbox"/> 5 – Positive & Energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – Depressed & Lethargic
DAY 4		<input type="checkbox"/> Caffeine (within 6 hours of bedtime) <input type="checkbox"/> Alcohol (within 1 hour of bedtime) <input type="checkbox"/> Medication (type: _____ )	<input type="checkbox"/> 5 – Positive & Energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – Depressed & Lethargic
DAY 5		<input type="checkbox"/> Caffeine (within 6 hours of bedtime) <input type="checkbox"/> Alcohol (within 1 hour of bedtime) <input type="checkbox"/> Medication (type: _____ )	<input type="checkbox"/> 5 – Positive & Energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – Depressed & Lethargic
DAY 6		<input type="checkbox"/> Caffeine (within 6 hours of bedtime) <input type="checkbox"/> Alcohol (within 1 hour of bedtime) <input type="checkbox"/> Medication (type: _____ )	<input type="checkbox"/> 5 – Positive & Energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – Depressed & Lethargic
DAY 7		<input type="checkbox"/> Caffeine (within 6 hours of bedtime) <input type="checkbox"/> Alcohol (within 1 hour of bedtime) <input type="checkbox"/> Medication (type: _____ )	<input type="checkbox"/> 5 – Positive & Energetic <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 – Depressed & Lethargic