

# Sleep Diary: Morning

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>Day of the week:</b>						
<b>I went to bed at:</b>						
AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
<b>I woke up at:</b>						
AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
<b>Last night, I slept for ____ hours:</b>						
<b>Last night, it took me about ____ minutes to fall asleep:</b>						
<b>I felt that the quality of my sleep was:</b> e.g. very good, good, bad, very bad						
<b>This morning, I feel:</b> e.g. refreshed, tired, groggy, alert						
<b>My sleep was made more difficult by:</b> e.g. temperature, noise, dreams, thoughts, not feeling tired, discomfort						
<b>During the night, I woke up ____ times:</b>						

# Sleep Diary: Night

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>I took a nap:</b>						
yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
<b>I had caffeine:</b>						
# of drinks	# of drinks	# of drinks	# of drinks	# of drinks	# of drinks	# of drinks
<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
<b>I exercised for ____ minutes:</b>						
<b>Medications or drugs I used today:</b>						
<b>Throughout the day, I felt drowsy:</b>						
<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often
<b>Overall, my mood today was:</b> e.g. positive, negative, neutral						
<b>In the hour before bed, my activities included:</b> e.g. reading, computer, TV, showering, phone, eating, spending time with partner						