

Complete in the Morning

Start date:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day of week:							
What time did you get into bed?	PM AM	PM AM	PM AM	PM AM	PM AM	PM AM	PM AM
What time did you try and go to sleep?	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
How long did it take you to fall asleep?	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.
What time did you wake up this morning?	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
How many times did you wake up during the night?							
No. of times							
No. of minutes							
Last night I slept a total of:	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.
How would you rate your sleep quality?							
Very Poor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Very Good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was your sleep disturbed by any factors? If so, list them here (ex. allergies, noise, pets, discomfort/pain, etc.)							
Any other comments about your sleep worth noting?							

Complete in the Evening

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day of week:							
I consumed caffeinated drinks in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
M / A / E / NA							
How many?							
How much exercise did you get today?							
No. of minutes							
Time of day (morning, afternoon, evening, night)							
Did you take a nap? (circle one)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If Yes, for how long?							
List all Medications you took today							
Approximately 2-3 hours before going to bed, I consumed:							
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A heavy meal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caffeine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not applicable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the hour before going to sleep, my bedtime routine included: List activities including reading a book, using electronics, taking a bath, doing relaxation exercises, etc.							