

Having Trouble Sleeping? We Can Help You.

Daily Sleep Diary

How This Sleep Diary Can Help You Get a Better Night's Sleep

A good night's sleep can have a powerful effect on your day and your alertness level. Lack of sleep can leave you feeling sluggish and out of focus, which can have a big impact on your day.

Recording your sleep patterns for just 7 days can lead to insights and understanding that may help you sleep better.

Using this sleep diary is quick and easy. Answer each day's questions for 7 days, and record any additional notes in the back of the guide.

You can choose to share this sleep diary with your doctor so they can help assess your sleep habits.



My Sleep Diary

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
About what time did you go to bed?	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM
How long did it take for you to fall asleep?	_____ Minutes	_____ Minutes	_____ Minutes	_____ Minutes	_____ Minutes	_____ Minutes	_____ Minutes
About how many times did you wake up during the night?	_____ Times	_____ Times	_____ Times	_____ Times	_____ Times	_____ Times	_____ Times
About how many hours did you sleep?	_____ Hours	_____ Hours	_____ Hours	_____ Hours	_____ Hours	_____ Hours	_____ Hours
Did you exercise at least 20 minutes today?	<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
What time did you get out of bed?	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM	_____ AM _____ PM
How refreshed did you feel when you got up this morning?	<input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Fatigued	<input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Fatigued	<input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Fatigued	<input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Fatigued	<input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Fatigued	<input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Fatigued	<input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Fatigued
How difficult was it for you to stay awake during the day?	<input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Difficult	<input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Difficult	<input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Difficult	<input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Difficult	<input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Difficult	<input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Difficult	<input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Difficult
Did you consume any of these substances during the day?	<input type="checkbox"/> Caffeine <small>within 6 hours of bedtime</small> <input type="checkbox"/> Alcohol <small>within 1 hour of bedtime</small> <input type="checkbox"/> Medication	<input type="checkbox"/> Caffeine <small>within 6 hours of bedtime</small> <input type="checkbox"/> Alcohol <small>within 1 hour of bedtime</small> <input type="checkbox"/> Medication	<input type="checkbox"/> Caffeine <small>within 6 hours of bedtime</small> <input type="checkbox"/> Alcohol <small>within 1 hour of bedtime</small> <input type="checkbox"/> Medication	<input type="checkbox"/> Caffeine <small>within 6 hours of bedtime</small> <input type="checkbox"/> Alcohol <small>within 1 hour of bedtime</small> <input type="checkbox"/> Medication	<input type="checkbox"/> Caffeine <small>within 6 hours of bedtime</small> <input type="checkbox"/> Alcohol <small>within 1 hour of bedtime</small> <input type="checkbox"/> Medication	<input type="checkbox"/> Caffeine <small>within 6 hours of bedtime</small> <input type="checkbox"/> Alcohol <small>within 1 hour of bedtime</small> <input type="checkbox"/> Medication	<input type="checkbox"/> Caffeine <small>within 6 hours of bedtime</small> <input type="checkbox"/> Alcohol <small>within 1 hour of bedtime</small> <input type="checkbox"/> Medication
Was your sleep disturbed by anything?							

