

Sleep Diary

Complete in the Morning

	I went to bed last night at:	Last night, I fell asleep in:	I woke up ___ times during the night and took ___ minutes to get back to sleep:	I woke up at:	When I woke up for the day, I felt: (Check one)	I got out of bed this morning at:	Last night I slept a total of: (Record number of hours)	My sleep was disturbed by: (List any mental, emotional, physical, or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)	Substances I took to help me sleep:	About 1 hour before going to sleep, I did the following activity: (List activities; e.g. watch TV, work, read, etc.)
Day 1 Day ____ Date ____	____PM/AM	____ Minutes	____ Times ____ Minutes	____AM/PM	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigues	____AM/PM	____ Hours	_____ _____ _____	_____ _____ _____	_____ _____ _____
Day 2 Day ____ Date ____	____PM/AM	____ Minutes	____ Times ____ Minutes	____AM/PM	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigues	____AM/PM	____ Hours	_____ _____ _____	_____ _____ _____	_____ _____ _____
Day 3 Day ____ Date ____	____PM/AM	____ Minutes	____ Times ____ Minutes	____AM/PM	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigues	____AM/PM	____ Hours	_____ _____ _____	_____ _____ _____	_____ _____ _____
Day 4 Day ____ Date ____	____PM/AM	____ Minutes	____ Times ____ Minutes	____AM/PM	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigues	____AM/PM	____ Hours	_____ _____ _____	_____ _____ _____	_____ _____ _____
Day 5 Day ____ Date ____	____PM/AM	____ Minutes	____ Times ____ Minutes	____AM/PM	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigues	____AM/PM	____ Hours	_____ _____ _____	_____ _____ _____	_____ _____ _____
Day 6 Day ____ Date ____	____PM/AM	____ Minutes	____ Times ____ Minutes	____AM/PM	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigues	____AM/PM	____ Hours	_____ _____ _____	_____ _____ _____	_____ _____ _____
Day 7 Day ____ Date ____	____PM/AM	____ Minutes	____ Times ____ Minutes	____AM/PM	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat Refreshed <input type="checkbox"/> Fatigues	____AM/PM	____ Hours	_____ _____ _____	_____ _____ _____	_____ _____ _____

